

DMB:DD:slg:2000V00797

JUDGE'S COPY

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF PENNSYLVANIA

PAUL LEE,

Plaintiff

v.

UNITED STATES OF AMERICA, et al.
Defendants

:
:
:
:
:
:
:

Civil No. 1:CV-00-00486
(Kane, J.)

FILED
HARRISBURG
DEC 11 2000
MARY E. D'ANDREA, CLERK
Per *[Signature]*
DEPUTY CLERK

RECORD TO BRIEF IN SUPPORT OF THE DEFENDANTS'
MOTION FOR SUMMARY JUDGMENT

DAVID M. BARASCH
United States Attorney

KATE L. MERSHIMER
Assistant U.S. Attorney
SHELLEY L. GRANT
Paralegal Specialist
217 Federal Building
225 Walnut Street
Post Office Box 11754
Harrisburg, PA 17108

Dated: December 11, 2000

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

PAUL LEE, :
 :
 Plaintiff : CIVIL NO. 1:CV-00-0486
 :
 v. : (Judge Kane)
 :
 UNITED STATES OF AMERICA, et-al., :
 :
 Defendants :

DECLARATION OF J. FROMM

I, J. Fromm, hereby declare and state as follows:

1. I am currently employed by the United States Department of Justice, Federal Bureau of Prisons ("FBOP"), as a Paralegal Specialist, at the Federal Correctional Complex (F.C.C.), Allenwood, Pennsylvania. I have been a Paralegal Specialist at F.C.C. Allenwood since August 1998. Prior to that time, I held the position of Paralegal Specialist at the United States Penitentiary, Lewisburg, Pennsylvania, since November, 1989.
2. In my official capacity, I have access to inmate files, including, but not limited to, records regarding an inmate's sentencing, disciplinary history, administrative tort claim filings and records relating to an inmate's history of incarceration.
3. I have reviewed the complaint in the above-captioned action,

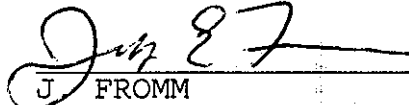
wherein the Plaintiff, inmate Paul Lee, Federal Register Number 01656-087, alleges that his left hip has degenerated since 1997 due to inappropriate bedding. The Plaintiff further alleges that he now suffers from degenerative arthritis and that medical staff have negligently failed to provide him with appropriate medical care and treatment for his injury.

4. The Plaintiff, inmate Paul A. Lee, Register No. 01656-087, was sentenced on January 30, 1995, in the United States District Court for the Northern District of West Virginia, to a term of imprisonment of two hundred months for: "Conspiracy to Possess With Intent to Distribute" and "Distribution of Cocaine a/k/a "Crack"" in violation of Title 21, United States Code §841(a)(1) and Title 21, United States Code, §846. The Plaintiff has a projected release date of March 26, 2010, via good conduct time release. The Plaintiff is currently housed at the Federal Correctional Institution (FCI) Allenwood, Pennsylvania.
5. The Plaintiff filed an administrative tort claim with the Northeast Regional Office, Federal Bureau of Prisons, which was received on February 9, 2000. The claim was assigned number TRT-NER-2000-449.
6. In his tort claim, the Plaintiff alleged "The BOP has cause my

hip to deteriorated by providing me with a steel bed and substandard mattress to sleep on. without a "box spring" By reason of the "BOP" cause negligence in their part not to provide me with proper bedding care". The Plaintiff did not raise any allegations of negligent medical care. I have attached a copy of claim TRT-NER-2000-449 to my declaration.

I declare that any and all records attached to this declaration are true and accurate copies of records maintained in the ordinary course of business by the Federal Bureau of Prisons. I further declare that the foregoing is true and correct to the best of my knowledge and belief, and is given under penalty of perjury pursuant to 28 U.S.C. §1746.

EXECUTED this 21st day of November, 2000.



J. FROMM
Paralegal Specialist
Federal Correctional Complex
Allenwood, Pennsylvania

DEC-11-00 MON 03:10 PM

ALLENWOOD LEGAL SERVICES

FAX NO. 17175476458

P. 02

**CLAIM FOR DAMAGE,
INJURY, OR DEATH****INSTRUCTIONS:** Please read carefully the instructions on the reverse side and supply information requested on both sides of this form. Use additional sheet(s) if necessary. See reverse side for additional instructions.**FORM APPROVED**
OMB NO.
1105-0008
EXPIRES 3-31-91

1. Submit To Appropriate Federal Agency:

2. Name, Address of claimant and claimant's personal representative, if any.
(See instructions on reverse.) (Number, street, city, State and Zip Code)
Paul Lee 01656-087

P.O. BOX 2000

White deer, Pa. 17887

3. TYPE OF EMPLOYMENT

4. DATE OF BIRTH

5. MARITAL STATUS

6. DATE AND DAY OF ACCIDENT

7. TIME (A.M. OR P.M.)

☐ MILITARY ☒ CIVILIAN

8. Basis of Claim (State in detail the known facts and circumstances attending the damage, injury, or death, identifying persons and property involved, the place of occurrence and the cause thereof) (Use additional pages if necessary.)

The "BOP" has cause my hip to deteriorated by providing me with a steel bed and substandard mattress to sleep on. without a "boxspring" By reason of the "BOP" cause negligence in their part not to provide me with proper bedding care.

9. **PROPERTY DAMAGE**

NAME AND ADDRESS OF OWNER, IF OTHER THAN CLAIMANT (Number, street, city, State, and Zip Code)

N/A

BRIEFLY DESCRIBE THE PROPERTY, NATURE AND EXTENT OF DAMAGE AND THE LOCATION WHERE PROPERTY MAY BE INSPECTED. (See instructions on reverse side.) "BOP" has cause server pain in my left hip, due to substandard mattress.

10. **PERSONAL INJURY/WRONGFUL DEATH**

STATE NATURE AND EXTENT OF EACH INJURY OR CAUSE OF DEATH, WHICH FORMS THE BASIS OF THE CLAIM. IF OTHER THAN CLAIMANT, STATE NAME OF INJURED PERSON OR DECEDENT.

N/A

11. **WITNESSES**

NAME

ADDRESS (Number, street, city, State, and Zip Code)

F.C.I A llenwood, Medical Service

P.O. BOX 2500

White deer, Pa. 17887

F.C.I Beckley, W.v.

P.O. BOX 1280

Beaver, Wv. 25813

12. (See instructions on reverse)

AMOUNT OF CLAIM (in dollars)12a. PROPERTY DAMAGE
cost of new hip12b. PERSONAL INJURY
2.5 m12c. WRONGFUL DEATH
N/A12d. TOTAL (Failure to specify may cause
forfeiture of your rights.)
2.5m

I CERTIFY THAT THE AMOUNT OF CLAIM COVERS ONLY DAMAGES AND INJURIES CAUSED BY THE ACCIDENT ABOVE AND AGREE TO ACCEPT SAID AMOUNT IN FULL SATISFACTION AND FINAL SETTLEMENT OF THIS CLAIM

13a. SIGNATURE OF CLAIMANT (See instructions on reverse side.)

13b. Phone number of signatory: 14. DATE OF CLAIM

**CIVIL PENALTY FOR PRESENTING
FRAUDULENT CLAIM**

The claimant shall forfeit and pay to the United States the sum of \$2,000. plus double the amount of damages sustained by the United States.
(See 31 U.S.C. 3729.)

**CRIMINAL PENALTY FOR PRESENTING FRAUDULENT
CLAIM OR MAKING FALSE STATEMENTS**

Fine of not more than \$10,000 or imprisonment for not more than 5 years or both. (See 18 U.S.C. 287, 1001.)

DEC-11-00 MON 03:10 PM

ALLENWOOD LEGAL SERVICES

FAX NO. 17175476458

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PRIVACY ACT NOTICE

This Notice is provided in accordance with the Privacy Act, 5 U.S.C. 552a(e)(3), and concerns the information requested in the letter to which this Notice is attached.

A. **Authority:** The requested information is solicited pursuant to one or more of the following: 5 U.S.C. 301, 28 U.S.C. 507 et seq., 28 U.S.C. 2671 et seq., 28 C.F.R. Part 14.

- B. **Principal Purpose:** The information requested is to be used in evaluating claims.
 C. **Routine Use:** See the Notices of Systems of Records for the agency to whom you are submitting this form for this information.
 D. **Effect of Failure to Respond:** Disclosure is voluntary. However, failure to supply the requested information or to execute the form may render your claim "invalid".

INSTRUCTIONS

Complete all items - Insert the word **NONE** where applicable.

A CLAIM SHALL BE DEEMED TO HAVE BEEN PRESENTED WHEN A FEDERAL AGENCY RECEIVES FROM A CLAIMANT, HIS DULY AUTHORIZED AGENT, OR LEGAL REPRESENTATIVE AN EXECUTED STANDARD FORM 25 OR OTHER WRITTEN NOTIFICATION OF AN INCIDENT, ACCOMPANIED BY A CLAIM FOR MONEY DAMAGES IN A SUM CERTAIN FOR INJURY TO OR LOSS OF

Any instructions or information necessary in the preparation of your claim will be furnished, upon request, by the office indicated in item #1 on the reverse side. Complete regulations pertaining to claims asserted under the Federal Tort Claims Act can be found in Title 28, Code of Federal Regulations, Part 14. Many agencies have published supplemental regulations also. If more than one agency is involved, please state each agency.

The claim may be filed by a duly authorized agent or other legal representative, provided evidence satisfactory to the Government is submitted with said claim establishing express authority to act for the claimant. A claim presented by an agent or legal representative must be presented in the name of the claimant. If the claim is signed by the agent or legal representative, it must show the title or legal capacity of the person signing and be accompanied by evidence of his/her authority to present a claim on behalf of the claimant as agent, executor, administrator, parent, guardian or other representative.

If claimant intends to file claim for both personal injury and property damage, claim for both must be shown in item 12 of this form.

The amount claimed should be substantiated by competent evidence as follows:

(a) In support of the claim for personal injury or death, the claimant should submit a written report by the attending physician, showing the nature and extent of injury, the nature and extent of treatment, the degree of permanent disability, if any, the prognosis, and the period of hospitalization, or incapacitation, attaching itemized bills for medical, hospital, or burial expenses actually incurred.

PROPERTY, PERSONAL INJURY, OR DEATH ALLEGED TO HAVE OCCURRED BY REASON OF THE INCIDENT. THE CLAIM MUST BE PRESENTED TO THE APPROPRIATE FEDERAL AGENCY WITHIN TWO YEARS AFTER THE CLAIM ACCRUES.

(b) In support of claims for damage to property which has been or can be economically repaired, the claimant should submit at least two itemized signed statements or estimates by reliable, disinterested concerns, or, if payment has been made, the itemized signed receipts evidencing payment.

(c) In support of claims for damage to property which is not economically repairable, or if the property is lost or destroyed, the claimant should submit statements as to the original cost of the property, the date of purchase, and the value of the property, both before and after the accident. Such statements should be by disinterested competent persons, preferably reputable dealers or officials familiar with the type of property damaged, or by two or more competitive bidders, and should be certified as being just and correct.

(d) Failure to completely execute this form or to supply the requested material within two years from the date the allegations accrued may render your claim "invalid". A claim is deemed presented when it is received by the appropriate agency, not when it is mailed.

Failure to specify a sum certain will result in invalid presentation of your claim and may result in forfeiture of your rights.

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden.

to Director, Torts Branch
 Civil Division
 U.S. Department of Justice
 Washington, DC 20530

and to the
 Office of Management and Budget
 Paperwork Reduction Project (1105-0008)
 Washington, DC 20503

INSURANCE COVERAGE

In order that subrogation claims may be adjudicated, it is essential that the claimant provide the following information regarding the insurance coverage of his vehicle or property.

15. Do you carry accident insurance? ☐ Yes. If yes, give name and address of insurance company (Number, street, city, State, and Zip Code) and policy number. ☐ No

N/A

16. Have you filed claim on your insurance carrier in this instance, and if so, is it full coverage or deductible?

17. If deductible, state amount:

N/A

N/A

18. If claim has been filed with your carrier, what action has your insurer taken or proposes to take with reference to your claim? (It is necessary that you ascertain these facts)

N/A

19. Do you carry public liability and property damage insurance? ☐ Yes. If yes, give name and address of insurance carrier (Number, street, city, State, and Zip Code) ☐ No

N/A

NOV-29-00 WED 12:26 PM ALLENWOOD LEGAL SERVICES

FAX NO. 17175476458

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U.S. Department of Justice

Federal Bureau of Prisons

Federal Correctional Institution

Allenwood Medium

P.O. Box 2500

White Deer, PA 17887-2500

May 24, 2000

MEMORANDUM FOR: HENRY J. SADOWSKI, REGIONAL COUNSEL
NORTHEAST REGION

A handwritten signature in cursive script, reading "Michael A. Zenk", is written over the typed name.

FROM: Michael A. Zenk, Warden

SUBJECT: T-NER-2000-449
LEE, Paul
Reg. No. 01656-087

This is in response to your request for an investigation and recommendation on the above-referenced administrative tort claim. Inmate Lee seeks compensation in the amount of \$2,500,000 for deterioration in his hip which he alleges occurred as a result of inadequate medical treatment. Specifically, he alleges that the Health Services Department should have provided a sturdier mattress which would have better supported his hip.

An investigation revealed that inmate Lee first began complaining of problems with his hip in July 14, 1997, long before his transfer to FCI-Allenwood. At that time, inmate Lee had a history of osteoarthritis, and an appointment was scheduled for December 9, 1997, with an orthopedic specialist. After an examination, the orthopedic specialist diagnosed the pain in inmate Lee's hip as Piriformis Syndrome (a compression of the sciatic nerve, causing pain centered in the hip and buttock area, and radiating up the back and down the legs.) As a result of this diagnosis, the affected area was injected with Depo-Medrol and Xylocaine, and inmate Lee was prescribed Indomethacin (an anti-inflammatory medication). Additional treatment includes physical therapy, an ultrasound to relieve muscle pressure, and anti-inflammatory medication. Following the December 9, 1997, consultation, inmate Lee was provided all of the appropriate treatment, and was educated regarding the use of heat therapy and anti-inflammatory medication.

Inmate Lee was not examined again with regards to his hip until July 24, 1998. At that time, he was diagnosed with an umbilical hernia and hip pain. He was again prescribed Indomethacin and was issued a referral for a steroid injection, however, he refused an orthopedic consultation. It was also determined at that time, that there was no need for a lower bunk restriction. On September 14, 1998, and November 2, 1998, he was again examined by Health Services staff. He was then diagnosed with left hip arthritis and prescribed Motrin.

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Inmate Lee was transferred to FCI-Allenwood from FCI-Beckley on November 16, 1998. Upon his arrival, it was noted that inmate Lee had a history of left hip bursitis. Inmate Lee was not examined again until April 26, 1999. At that time, he complained of a cough and cold along with his ongoing hip bursitis. An examination at that time revealed decreased range of motion at all points, positive point tenderness over the joint without erythema or signs of inflammation. He was again prescribed Motrin for the pain.

As a result of the April 26, 1999, examination, medical staff requested an X-Ray and orthopedic consult. On June 2, 1999, an X-Ray was taken of inmate Lee's left hip. The X-Ray revealed severe degenerative change in the left hip joint, consistent with the degenerative change associated with degenerative joint arthritis. The results of this X-Ray were subsequently reviewed with inmate Lee.

On July 14, 1999, inmate Lee was examined by the orthopedic specialist who indicated that inmate Lee may be a future candidate for hip replacement surgery. Until such time as inmate Lee qualified for the surgery, however, he was offered a cane and a local injection for the pain. Inmate Lee refused this course of treatment.

On December 14, 1999, inmate Lee again requested to see the specialist regarding his left hip. On February 4, 2000, inmate Lee's hip was again X-Rayed, revealing bilateral osteoarthritis, left greater than right. Inmate Lee was then examined by the orthopedic specialist on April 12, 2000. At that time, the specialist recommended the use of a cane and anti-inflammatory medication. Inmate Lee was further advised that if he remained compliant with the prescribed medication and cane, but his condition continued to deteriorate, then hip surgery would be examined at a later date. Inmate Lee has not been examined with regards to his hip since April 12, 2000.

Based on the above information, this investigation has failed to reveal the existence of any staff negligence. Specifically, the evidence in this matter reveals that staff appropriately tended to inmate Lee's medical needs. Therefore, I recommend that this administrative tort claim be Denied. Should you have any questions concerning this matter, please feel free to contact Douglas S. Goldring, Attorney, at (570)547-7950, ext. 5116.

NOV-29-00 WED 12:27 PM ALLENWOOD LEGAL SERVICES

FAX NO. 17175476458

P. 03

UNITED STATES GOVERNMENT
MEMORANDUM
FCI ALLENWOOD

DATE: April 25, 2000

REPLY TO
ATTN OF: J. Hutton, Acting HSASUBJECT: TRT-NER-00-4
Lee, Paul
Reg.No. 23877-083

TO: Mike Sullivan, Supervisory Attorney

This is in response to the tort claim filed by inmate Lee, Paul Reg.No. 01656-087, in which he states that the "BOP" has caused his hip to deteriorate because he has not been provided proper bedding care.

After a careful review of his medical records, July 14, 1997, is the first medical documentation regarding pain in his hip. His medical record states a history of osteoarthritis. Inmate Lee complained about hip pain and was evaluated by an orthopedic specialist on December 9, 1997. This consultation states Piriformis syndrome and the area was injected with Depo-Medrol and Xylocaine. He was also prescribed Indomethacin which is an anti inflammatory medication. Piriformis syndrome is a condition marked by pain in the hip and buttock that radiates up into the lower back and down the leg. This is caused by entrapment of the sciatic nerve as it passes through the piriformis muscle in the buttock. Because the symptoms mimic those caused by a herniated lumbar disk, the syndrome may be confused with that disease. Treatment includes physical therapy to relieve pressure, ultrasound to reduce muscle spasm, and anti-inflammatory medicine. Inmate Lee received the appropriate treatment at that time and was educated regarding the use of heat and anti inflammatory medication.

On July 24, 1998, inmate Lee was examined in health services for umbilical hernia and hip pain. He was given a prescription for Indomethacin and a referral for steroid injection was written. It was noted at the time "no need for low bunk". Inmate Lee was a no show for his orthopedic consult.

On September 14, 1998, he was evaluated and was prescribed Indomethacin and another orthopedic consult was written. He was evaluated on November 2, 1998, for "left hip arthritis" and requested pain medication. He was given a prescription for Motrin, another anti inflammatory medication.

Inmate Lee arrived at FCI Allenwood on November 16, 1998, from FCI Beckley. Upon

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P. 04

in sick call for congestion and cough and history of left hip bursitis. Examination revealed decreased range of motion all points, positive point tenderness over joint without erythema or signs of active inflammation. He was given a prescription for Motrin to be taken as needed for pain. An x-ray of the left hip and an orthopedic consult were requested. X-ray report of the left hip on June 2, 1999, revealed severe degenerative changes of the left hip joint. This type of degenerative change is expected with severe degenerative joint arthritis. On July 6, 1999, x-ray results were discussed with inmate Lee and treatment options were explained.

On July 14, 1999, inmate Lee was examined by an orthopedic specialist and instructed he could be a candidate for hip replacement in the future and was offered a cane and local injection which he refused.

On December 22, 1999, inmate Lee requested to see the doctor regarding his left hip. An orthopedic referral was submitted and x-rays were ordered. X-rays from February 4, 2000, reported bilateral osteoarthritis, left greater than right.

On April 12, 2000, inmate Lee was seen by an orthopedic specialist who recommended using a cane and anti inflammatory medication and he agreed to try using a cane. Hip surgery will be discussed in the future if he is compliant with cane and medications.

As outlined above inmate Lee has been examined several times for his hip by orthopedic specialists. There is no documentation that the type of bedding provided to inmate Lee caused his hip to further deteriorate. The deterioration he has experienced is a natural progression of his condition. There is no proof that a substandard mattress has caused his hip pain and his tort claim should be denied.

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

PAUL LEE, :
 :
Plaintiff : CIVIL NO. 1:CV-00-0486
 :
v. : (Judge Kane)
 :
UNITED STATES OF AMERICA, et-al., :
 :
Defendants :

DECLARATION OF R. MIGLIORINO, D.O.

I, R. MIGLIORINO, hereby declare and state as follows:

1. I am currently employed by the United States Department of Justice, Federal Bureau of Prisons ("FBOP"), as the Clinical Director at the Federal Correctional Institution (F.C.I.), Allenwood, Pennsylvania. I have been employed with the FBOP since April 1996. Prior to that time, I was assigned to the medical staff at the Sioux San Hospital Rapid City, South Dakota. As a Clinical Director, I have access to Bureau of Prisons records, including but not limited to medical records and records denoting places of incarceration.
2. I have reviewed the complaint in the above-captioned action, wherein the Plaintiff, inmate Paul Lee, Federal Register Number 01656-087, alleges that his left hip has degenerated since 1997 due to inappropriate bedding. The Plaintiff further alleges that he now suffers from degenerative arthritis and that medical staff have negligently failed to provide him with appropriate medical care and treatment for

his injury.

3. A review of the Plaintiff's records reveals that the Plaintiff entered into the custody of Federal Bureau of Prisons on July 30, 1991, and he was released from custody on July 15, 1992, via good conduct time release.
4. On February 17, 1995, the Plaintiff once again entered into the custody of the Bureau of Prisons, and on March 10, 1995, he arrived at F.C.I. McKean, Pennsylvania.
5. On March 30, 1995, the Plaintiff was transferred to F.C.I. Cumberland, Maryland.
6. On September 18, 1995, the Plaintiff had an x-ray of his lower back taken. Medical staff noted that the Plaintiff had mild diffuse degenerative arthritis of the lumbar spine.
7. On February 5, 1996, the Plaintiff was transferred to F.C.I. Beckley, West Virginia, arriving there on February 20, 1996.
8. My review of the Plaintiff's medical records reveals that the first complaint made by the Plaintiff concerning his left hip was made on or about July 14, 1997. The Plaintiff was seen by medical staff and he was prescribed Tylenol. At that time, the Plaintiff indicated to staff that he had a history of

osteoarthritis.

9. On August 4, 1997, the Plaintiff was seen by medical staff. The Plaintiff complained that his left hip was "aching". The Plaintiff was prescribed Motrin, he was told to apply heat three times a day, and an orthopedic consultation was ordered for an injection which was to be canceled if the Plaintiff got better. Medical staff at that time suspected that the Plaintiff was suffering from bursitis.
10. On September 15, 1997, the Plaintiff was seen by medical staff for lower back pain. It was noted that the Plaintiff had full range of motion, but his back was tender. The Plaintiff was prescribed Motrin and heat. The Plaintiff was instructed to report to sick call if needed.
11. On October 14, 1997, the Plaintiff was again seen by medical staff. Medical staff once again diagnosed the Plaintiff as suffering from bursitis. The Plaintiff was prescribed Motrin, he was instructed to apply heat and to return to health services as needed.
12. On December 9, 1997, the Plaintiff was examined by an orthopedic specialist regarding the consultation which had been ordered on August 4, 1997. During this examination, the

orthopedic specialist noted that the Plaintiff had Piriformis Syndrome. The affected area was injected with Depo-Medrol and Xylocaine. The Plaintiff was also prescribed Indomethacin which is an anti-inflammatory medication.

13. On February 13, 1998, the Plaintiff reported for sick call complaining of a callous on his right foot. The Plaintiff did not complain of any left hip pain during that visit.
14. On May 14, 1998, the Plaintiff reported for sick call complaining of pain in his left elbow. Once again, the Plaintiff did not complain of any left hip pain.
15. On May 22, 1998, the Plaintiff reported for sick call complaining of a cold. Once again, the Plaintiff did not complain of any left hip pain.
16. On July 24, 1998, the Plaintiff was examined by medical staff for umbilical hernia and left hip pain. The Plaintiff was prescribed Indomethacin and a referral for steroid injection was made. Medical staff noted that the Plaintiff did not require a lower bunk in his quarters. The record further indicates that the Plaintiff failed to appear for his scheduled orthopedic consultation with the orthopedic specialist.

17. On September 15, 1998, the Plaintiff was evaluated by medical staff and he requested another injection. An orthopedic consultation was again scheduled and the Plaintiff was prescribed Indomethacin. An orthopedic consultation was also scheduled with the orthopedic specialist.
18. On October 26, 1998, the Plaintiff was transferred to F.C.I. Allenwood, Pennsylvania, arriving there on November 16, 1998.
19. On November 2, 1998, the Plaintiff was evaluated by medical staff for "left hip arthritis" and he requested medication for pain. The Plaintiff was prescribed Motrin.
20. On November 16, 1998, the Plaintiff arrived at FCI Allenwood. Upon his arrival, a history of left hip bursitis was noted in his medical record.
21. The Plaintiff was not seen by medical staff until April 19, 1999, after he complained of pigmentation of the skin under his eyes. The Plaintiff did not make any complaints of hip pain.
22. On April 26, 1999, the Plaintiff reported for sick call complaining of congestion, coughing, a hernia and left side

bursitis. It was noted during this visit that the Plaintiff had a history of left hip bursitis. An examination of the Plaintiff's left hip revealed a decreased range of motion of all fields, positive point tenderness over the joint without erythema or signs of active inflammation. The Plaintiff was prescribed Motrin to be taken as needed for pain. Medical staff diagnosed the Plaintiff as suffering from left hip bursitis by history, which means that he has a history of bursitis but no present indication or complaints of bursitis. An x-ray of the Plaintiff's hip was ordered and a consultation request was made for an orthopedic specialist to evaluate his hip.

23. On April 30, 1999, the Plaintiff was seen by medical staff complaining that the cold medication he was taking was not working. Once again, the Plaintiff failed to make any complaints regarding his left hip.
24. On June 2, 1999, an x-ray report revealed that the Plaintiff had severe degenerative changes of the left hip joint.
25. On June 23, 1999, the Plaintiff failed to appear for a scheduled sick call appointment.
26. On July 6, 1999, the results of the x-ray were discussed with

the Plaintiff. Medical staff discussed degenerative joint disease with the Plaintiff and various treatment options were explained. The Plaintiff was also instructed that he will be seeing an orthopedic specialist.

27. On July 14, 1999, the Plaintiff was evaluated by an orthopedic specialist. The orthopedic specialist indicated to the Plaintiff that he could be a candidate for hip replacement in the future, but that at the present time he appeared to be too young for such a procedure. The Plaintiff was then offered a cane and a local injection. The Plaintiff refused both of these options.

28. On August 13, 1999, the Plaintiff was seen by medical staff for an injury. Once again, the Plaintiff failed to make any complaints of left hip pain.

29. On August 18, 1999, the Plaintiff reported to sick call and requested a prostate exam. Once again, the Plaintiff failed to make any complaints of left hip pain.

30. On September 2, 1999, the Plaintiff was given a physical examination. Once again, the Plaintiff failed to make any complaints of left hip pain.

31. On November 29, 1999, the Plaintiff was seen by medical staff complaining of a lump on his foot (callous). Staff diagnosed him as having foot fungus. Once again, the Plaintiff failed to make any complaints of left hip pain.
32. On December 9, 1999, the Plaintiff reported to sick call complaining of an injury. Once again, the Plaintiff failed to make any complaints of left hip pain.
33. On December 22, 1999, the Plaintiff requested to see the doctor regarding his left hip. An orthopedic referral was submitted and x-rays were again ordered to be taken.
34. On January 6, 2000, a consultation request for an orthopedic specialist was written. The record revealed severe degenerative joint disease of the left hip.
35. On February 4, 2000, a review of the x-ray films revealed bilateral osteoarthritis. The left side was noted to be greater than the right.
36. On April 12, 2000, the Plaintiff was seen by an orthopedic specialist who recommended that the Plaintiff use a cane and take anti-inflammatory medication. The Plaintiff was somewhat resistant to using a cane and the orthopedic specialist

explained why the cane would be beneficial. The Orthopedic specialist stated that when the Plaintiff was ready to discuss hip surgery it would be reasonable to have this discussion with him.

37. On May 8, 2000, the Plaintiff made a request for two copies of his orthopedic consultations.

38. On May 19, 2000, the Plaintiff's medications were refilled. It was noted that the Plaintiff has a history of degenerative joint disease. The Plaintiff was prescribed Motrin with one refill.

39. On June 26, 2000, the Plaintiff was provided with a copy of his orthopedic consultation, per his May 8, 2000, request.


40. On July 11, 2000, the Plaintiff was treated for a complaint of dry skin. Once again, the Plaintiff failed to make any complaints of left hip pain.

41. On August 22, 2000, the Plaintiff was given a physical examination as a pre-requisite to working in food service. The examination was essentially normal with no medical complaints noted at that time. Once again, the Plaintiff failed to make any complaints of left hip pain.

42. On October 6, 2000, the Plaintiff reported to sick call complaining of sinus congestion. Once again, the Plaintiff failed to make any complaints of left hip pain.
43. As of November 20, 2000, the Plaintiff has not requested to see the orthopedic specialist to discuss having a hip replacement.
44. Based on my review of the Plaintiff's medical records, there is no record that the Plaintiff has ever complained that his hip condition was caused by inappropriate bedding. In fact, his record actually reveals that he is suffering from degenerative joint disease.
45. The Plaintiff is still being housed at F.C.I. Allenwood.
46. I have attached a copy of the Plaintiff's medical records from January 1, 1997, through the present, to my declaration.

I declare that any and all records attached to this declaration are true and accurate copies of records maintained in the ordinary course of business by the Federal Bureau of Prisons. I further declare that the foregoing is true and correct to the best of my knowledge and belief, and is given under penalty of perjury pursuant to 28 U.S.C. §1746.

EXECUTED this 21st day of November, 2000.



R. MIGLIORINO, D.O.
Clinical Director
Federal Correctional Institution
Allenwood, Pennsylvania 17887

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
8-22-00 (CONT)	<p>EVALUATION FOR ASSIGNMENT TO FOOD SERVICE (CONTINUED)</p> <p>Results of Hepatitis Serologic Testing (if indicated):</p> <p>Other Tests Results (as indicated)</p> <p>A. Qualified for Food Service? YES <input checked="" type="radio"/> NO <input type="radio"/></p> <p>P. Follow up for treatment medically indicated? YES <input type="radio"/> NO <input checked="" type="radio"/></p> <p>If Yes: placed in appropriate clinic? YES <input type="radio"/> NO <input checked="" type="radio"/></p> <p>Schedule for re-evaluation in 1 Year? YES <input checked="" type="radio"/> NO <input type="radio"/></p> <p style="text-align: right;">N. Manenkoff, PA-C Robert Manenkoff, PA-C Physician Assistant</p>
10-6-00 1715	<p>S. Sinus congestion at night causing him to sneeze. No cough or rhinorrhea</p> <p>O. HEENT WNL</p> <p>A. Possible allergy</p> <p>P. Pt. Ed. use saline spray or CTM available in commissary</p> <p>Pt. understands + agrees.</p> <p style="text-align: right;">N. Manenkoff, PA-C Robert Manenkoff, PA-C Physician Assistant</p>

NSN 7540-00-634-1176

800-108

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)

8-22-00

S. EVALUATION FOR ASSIGNMENT TO FOOD SERVICE

PERTINENT MEDICAL HISTORY (Circle appropriate responses below)

H/O Tuberculosis

YES

NO

H/O Positive Mantoux or PPD

YES

NO

POS PPD

H/O BCG Vaccination

YES

NO

TX 1995

H/O Jaundice or Hepatitis

YES

NO

H/O Any Sexually Transmitted Disease

YES

NO

H/O Intravenous Drug Use

YES

NO

H/O Positive HIV Serology

YES

NO

H/O Pulmonary Disease

YES

NO

H/O Skin Lesions

YES

NO

Explain all YES responses or provide any other history as indicated.

O. Vital Signs: B/P 120/70 Pulse 68 Resp /6 Temp 98 Wt 221

FULL SKIN EXAM: Evidence of open sores, skin lesions, wounds, or any contagious skin condition?

YES

NO

HEENT EXAM:

Icterus?

YES

NO

Oral, pharyngeal, and nasal mucous membranes lesions?

YES

NO

Any tympanic membranes abnormalities?

YES

NO

CHEST EXAM: Any adventitious breath sounds?

YES

NO

ABDOMINAL EXAM:

Tenderness?

YES

NO

Hepatomegaly?

YES

NO

Splenomegaly?

YES

NO

GU EXAM

Penile lesions?

YES

NO

Urethral discharge?

YES

NO

LYMPH NODES EXAM

Any evidence of palpable submandibular, cervical, supraclavicular, axillary or inguinal lymphadenopathy?

YES

NO

PPD TESTING:

Date Performed

1995

Results: Negative

Positive

15 mm induration

RPR TESTING:

Date Performed

8-8-95

Results: Non-reactive

Reactive

dils titer

HIV TESTING:

Date Performed

2-8-92

Results: Non-reactive

Reactive

(OVER)

PATIENT'S IDENTIFICATION (Use this space for Mechanical Imprint)

RECORDS
MAINTAINED
AT:

PATIENT'S NAME (Last, First, Middle Initial)

LEE, PAUL

SEX

RELATIONSHIP TO SPONSOR

STATUS

RANK/GRADE

SPONSOR'S NAME

ORGANIZATION

DEPART./SERVICE SSN/IDENTIFICATION NO.

DATE OF BIRTH

FCI - ALLENWOOD

PO Box 2500

White Plains, NY 10603

D/L-4-287

RADIOLOGIC CONSULTATION REQUEST/REPORT

U.S. DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF PRISONS

PATIENT NAME
PAUL LEE

ACCOUNT NO
49248

RADIOLOGY NUMBER
001656087

AT THE REQUEST OF
**DEBRA SPOTTS LPN
FCI ALLENWOOD
P.O. BOX 2500
WHITE DEER, PA 17887**

DATE OF BIRTH
04/11/1953

AGE/SEX
47/M

DATE OF SERVICE
07/19/2000

07/19/2000: 071010 CHEST 1 VIEW FM# 919-00

DIAGNOSIS: Chronic infiltrate right base, no acute infiltrates are observed.

COMMENTS: The heart size is top normal with out vascular congestion. Bronchial thickening and chronic infiltrate is noted in the right base unchanged since the prior study. No acute changes are identified at this time.

ELECTRONICALLY SIGNED
Joseph B. Bellissimo, M.D.
JBB/nw
D&T: 083100

CC: ROBERT MIGLIORINO DO

Robert Migliorino, DO
ROBERT MIGLIORINO, DO

STANDARD FORM 600 BACK (REV. 5-84)

U.S. Government Printing Office: 1994 - 300-882/10016

7-11-00 S. M. clo bilateral dry skin on feet and regrowth nails trimmed.

1732 D. feet bilateral dry skin over lateral aspect of feet & fissures
p. d. d. callus

A: B/L dry skin feet

68725 P 1. Trimmed toenails bilaterally 2. Vaseline cream bid x 30 days

2. ~~Ob. Derm lotion~~ ^{error GC 7/1/00} ~~apply to affected areas bid x 30 days~~

3.

**PATIENT ED. AND INSTRUCTION GIVEN
AND PT VERBALIZES UNDERSTANDING****ABOUT** med use, skin/foot care, follow-up in.

Schmidt, M.

68724

4. Size 7 shoe inserts

E. Ch. Skott H. C.

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)

DATE

ISN 7500-00-834-4178

800-108

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
5/3/00 1306	ADMINISTRATIVE NOTE: Per written request by Mr. Lee, Paul 2 copies of ortho consult dated 12/13/99 and 7/14/99 given to Mr. D. Spethman. Lee-Anne Whitmyre, MIT
5-19-00 1420	S/meds Refill O/Affected A/STX HX. P/- Naproxen 275mg #60 RX1 Envy Sig: T PO. BID
66230	- ACTifed Tab. # 30 Sig: T PO. TID. X 10 days. PRN
66231	- IBU 800mg. Tab. #60 Sig: T PO. BID 1 R gift. - PATIENT ED. AND INSTRUCTION GIVEN AND PT VERBALIZES UNDERSTANDING
6/2/00	ABOUT <u>Medication & Caution</u> Ulises Vargas, HSA, MUP
6/26/00	Adm. Note: Per written request by Mr. Lee - 1 copy of ortho consult dated 1/12/00 D. Spethman D. SATURN

PATIENT'S IDENTIFICATION (Use this space for Mechanical Imprint)

RECORDS MAINTAINED AT:	FCI-Allenwood, PO Box 2500, White Deer P		
PATIENT'S NAME (Last, First, Middle Initial)	Lee, Paul		SEX
RELATIONSHIP TO SPONSOR	STATUS	RANK/GRADE	
SPONSOR'S NAME		ORGANIZATION	
DEPART./SERVICE	ISN/IDENTIFICATION NO. 01656-087	DATE OF BIRTH	

DEPARTMENT OF JUSTICE
Federal Bureau of Prisons

INMATE REQUEST OF STAFF MEMBER

DATE June 6, 000

TO: Health Admin. Mr. Vargas
(Name and title of officer)

SUBJECT: State completely but briefly the problem on which you desire assistance, and what you think should be done (Give details).

Requesting to have surgery done to mine large hernia of my
"navel" that may be threatening if the blood supply to mine bulging
intestine are cut-off. If mine intestine are cut-off,
spreads of germs throughout the abdomen, in the event could cause
great pain to me.

Use other side of page if more space is needed

NAME: Paul Lee No: 01656-087
Work assignment: Glenn F/S Unit: three b

NOTE: If you follow instructions in preparing your request, it can be disposed of more promptly and intelligently. You will be interviewed, if necessary, in order to satisfactorily handle your request. Your failure to specifically state your problem may result in no action being taken.

Received 7-7-00

DISPOSITION: (Do not write in this space)

DATE

7/7/00

*Paul: you need to make sick call to be evaluated
for your request. if the PA. clinically find that
my is necessary and under BOP guidelines he has to
let to the warden for approval.*

FCI - ALLENTOWN
PO Box 2500

Officer

21

DATE

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)

BP-362 (INMATE INJURY REPORT)

COMPLETED ON THIS DATE.

PM 2/1/00

ROBERT MIGLIORINO, D.O.

R. J. Mayshock, PA-C

VMD BY LEBVY/1522 UNDERSTANDING
WHENLED VMD INSTRUCTION GIVEN

4/12/00

ADMINISTRATIVE NOTE:

ortho clinic

11⁰⁰

- wants I.M. to use a cane - I.M. willing to give it a try
- 6 wt. use B.122, walk Avoid high impact activity
- Naproxen 275mg + P.O. BID x 30 days. NR's.

60155

May take it QHS dose if needed. not to excite 2 doses.

will discuss hip surgery w/ Pt. if he is compliant w/ Kane & meds

J. Johnson

J. Johnson

ADMINISTRATIVE NOTE:

4/26/00

1140

Records copied from 2/96 to present to facilitate
response to tort claim TRT-VER-00-449.Copies included x-Ray reports, BP000 notes,
ortho consults, medical history report, report of
medical exam and medical status forms
total 26 pages.

W. Rehm, Medical Secretary

W. Rehm,
Medical Secretary

500-108

L RECORD OF MEDICAL CARE

TREATING ORGANIZATION (Sign each entry)

Today

N L W

R.J. Mayshech, PA-C

facilitate response

R-99-364

to present including
total.

W. Rehm Medical Secretary

W. Rehm Medical secretary

o lab work check up. ~~Place~~aspect. @ foot ~~Lab for~~

ves @ foot

chem profile

Robert Manenkoff, PA-C

Physician Assistant

at last soak foot warm water

First, Middle Initial		SEX
PAC		
ORION	STATUS	RANK/GRADE
ORGANIZATION		

N/IDENTIFICATION NO.	DATE OF BIRTH
01656-087	4-11-53

513-110

NSN 7540-00 634 412

MEDICAL RECORD

CONSULTATION SHEET

183

REQUEST

TO:

Ortho

FROM: (Requesting physician or activity)

F.A. Terrero-Pena, MLP, PA

DATE OF REQUEST

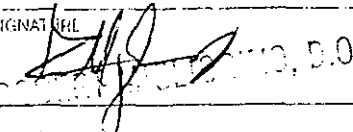
1-6-200

REASON FOR REQUEST (Complaints and findings)

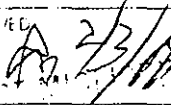
46 y.o. BO ♂ c severe DDD of L Hip.
Please evaluate. Thank you.

PROVISIONAL DIAGNOSIS

DOCTOR'S SIGNATURE



APPROVED



PLACE OF CONSULTATION

☒ BEDSIDE☐ ON CALL☒ ROUTINE☐ TODAY☐ 72 HOURS☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NOPATIENT EXAMINED ☐ YES ☐ NO

4-12-00

I saw Mr. Paul Lee before. He had some repeat x-rays of his left hip and tells me the hip bothers him, particularly at night. He has refused to use a cane at this point. We talked about it once again. If he requests one and thinks it is of any use, I think it is a good thing to try. He does work out. I think that is great that he is trying to keep his weight under control.

His exam is about the same. He has pain beyond 90° and up at about 90° he wants to abduct somewhat. On internal rotation he goes to just beyond neutral and then he has pain. His distal neurovascular status is grossly intact.

He is only 46 years old, and he may benefit from a good course of Naprosyn or Motrin. He does tell me he takes Naprosyn daily, so I think they can make a balance reason for all of this. His hip doesn't inhibit him from working out, but it is pretty miserable at night. When he wants to talk about a hip replacement I think it would be reasonable to have this discussion with him and perhaps even have Dr. Hahn give him a surgical talk. He is somewhat resistant to the cane, and I told him why I think it would be beneficial to at least try it and give a fair trial at that. I will see him as needed.

John T. Magill, III, M.D./hh

cc: Health Services

(Continue on reverse side)

SIGNATURE AND TITLE

DATE
ROBERT MAGILL, III, M.D.

IDENTIFICATION NO.

ORGANIZATION

REGISTER NO.

WARD NO.

PATIENT'S IDENTIFICATION (For typed or written entries give: Name--last, first, middle; grade; rank; rate; hospital or medical facility)

FCI - ALLENWOOD
PO Box 2500
White Deer PA. 17887

Lee, Paul A.
01656-087

Y
aging

933 ZEIGLER ROAD
LEWISBURG, PA 17837
(570) 522-9300
(888) 522-5540
FAX (570) 522-9304
FAX (888) 522-5541

Services

Open MRI
Spinal CI
Mammography
Ultrasound
X Ray

Professional Services
Provided By Tristán
Associates

Finan O. Bahia, M.D.
Joseph B. Bellissimo, Jr., M.D.
Brian P. Bloom, M.D.
Dean M. Brockmole, M.D.
Milton A. Friedlander, M.D.
Mark A. Guenin, M.D.
James R. Hills, M.D.
Joachim I. Huerter, M.D.
Judith A. Jozefiak, M.D.
Michael J. Mandell, M.D.
Ellen M. O'Mara, D.O.
Albert R. Porter, M.D.
Donald J. Schnapf, D.O.
James W. Warren, M.D.

Affiliated Offices

YORK IMAGING CENTER
1640 South Queen Street
York, PA 17403
(717) 843-8983
(800) 648-7489

TRISTAN ASSOCIATES
4518 Union Deposit Road
Harrisburg, PA 17111
(717) 652-5840
(888) 452-5840

TRISTAN ASSOCIATES
32 Northeast Drive
Suite 101
Hershey, PA 17033
(717) 533-1736

Paul Lee 01656-087
Bilateral Hips
02/04/00

COMMENT: AP & frog leg views of both hips were obtained. Degenerative changes of the acetabuli are identified, left greater than right. There is marked bony productive change about the inframedial and supralateral aspect of the left acetabulum. There is joint space narrowing on the left greater than right. No fractures or acute bony abnormalities are seen.

IMPRESSION: 1) Bilateral osteoarthritis, left greater than right.

JAJ/nlw
D&T: 021800

JAJ
Judith A. Jozefiak, M.D.

ROBERT MIGLIORINO, D.O.
12/14/22/00

U.S. DEPARTMENT OF JUSTICE
Federal Bureau of Prisons

INMATE REQUEST NO STAFF MEMBER

02-1-00

DATE

TO: Dr. Migliorino F.C.I. Allenwood
(Name and title of officer)

SUBJECT: State completely but briefly the problem on which you desire assistance, and what you think should be done (Give details).

Requesting, know what kind of exercise that I am permitted to do here, since you have denied me my right to exercise, because of my degenerative joint disease of the hip.

(Use other side of page if more space is needed)

NAME: Paul Lee No.: 01656-087
Work assignment: F/S Unit: three -b

NOTE: If you follow instructions in preparing your request, it can be disposed of more promptly and intelligently. You will be interviewed, if necessary, in order to satisfactorily handle your request. Your failure to specifically state your problem may result in no action being taken.

DISPOSITION: (Do not write in this space)

DATE

2/1/00

After reviewing your medical chart, you have no restrictions listed at this facility.

[Signature] ROBERT MIGLIORINO, D.O.
Officer

INMATE REQUEST TO STAFF MEMBER
APR 94

UNITED STATES DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF PRISONS

DATE 12-22-99

TO: Health Service, Doctor, in charge of Orthopedics

SUBJECT: State completely but briefly the problem on which you desire assistance and what you think should be done (Give details).

Requesting to see the Doctor, concerning my left hip, why I am restricted from any actives.

(Use other side of page if more space is needed)

NAME: Paul lee

No.: 01656-087

Work Assignment: F/S

Unit: three (b)

NOTE: If you follow instructions in preparing your request, it can be disposed of more promptly and intelligently. You will be interviewed, if necessary, in order to satisfactorily handle your request. Your failure to specifically state your problem may result in no action being taken.

DISPOSITION: (do not write in this space)

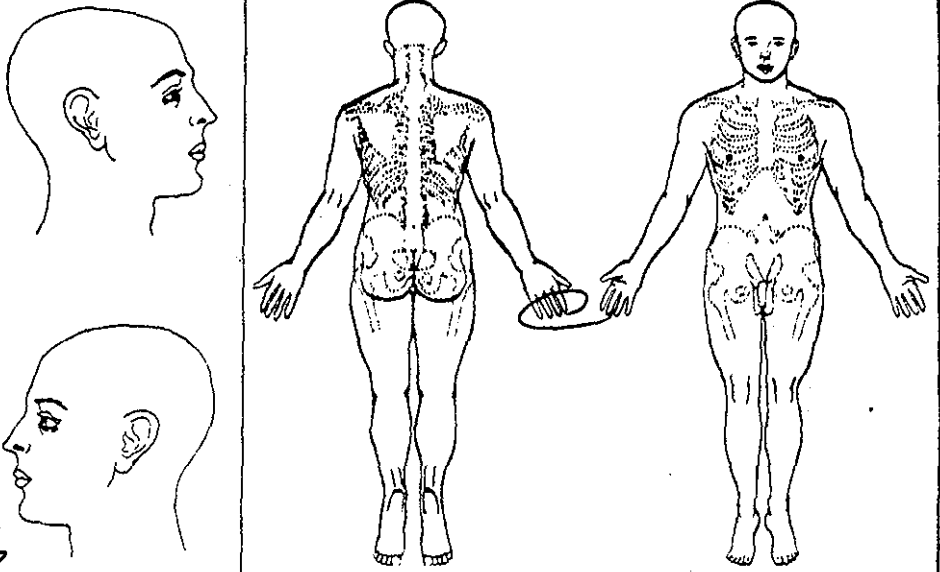
DATE 1-6-2000

You have been referred to Ortho.
New X-Rays were ordered of your hips. Watch
call out for X-Rays and then Ortho.

P. Penner-Pena

U.S. DEPARTMENT OF JUSTICE
Federal Bureau of Prisons

INMATE INJURY ASSESSMENT AND FOLLOWUP
(Medical)

1. Institution FCI MICHIGANWOOD	2. Name of Injured LEE PAUL	3. Register Number 01656-087
4. Injured's Duty Assignment FS	5. Housing Assignment 2B	6. Date and Time of Injury 12-9-88 0815
7. Where Did Injury Happen (Be specific as to location) FS	Work Related? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	8. Date and Time Reported for Treatment 12-9-88 0830
9. Subjective: (Injured's Statement as to How Injury Occurred)(Symptoms as Reported by Patient) SCRAPPED KNUCKLES on SEE JAIL CART R. G. Signature of Patient		
10. Objective: (Observations or Findings from Examination) Small Abrasion on @ 3rd + 4th Fing	X-Rays Taken _____ Not Indicated <input checked="" type="checkbox"/> X-Ray Results	
11. Assessment: (Analysis of Facts Based on Subjective and Objective Data) ABRASION		
12. Plan: (Diagnostic Procedures with Results, Treatment and Recommended Follow-up) ANTISEPTIC WASH - ANTIBIOTIC BANDAGES Edue: Keep clean + dry. RZC PRN analgesic scrapes - Bandages issued		
13. This Injury Required: <input type="checkbox"/> a. No Medical Attention <input checked="" type="checkbox"/> b. Minor First Aid <input type="checkbox"/> c. Hospitalization <input type="checkbox"/> d. Other (explain) <input type="checkbox"/> e. Medically Unassigned <input type="checkbox"/> f. Civilian First Aid Only <input type="checkbox"/> g. Civilian Referred to Community Physician		
Signature of Physician or Physician Assistant MAX HALL		

Original - Medical File

Canary - Safety

Pink - Work Supervisor (Work related only)

Self Carboned Form - If ballpoint pen is used, PRESS HARD

ROBERT MICHAELSON, D.O.

REPORT OF MEDICAL EXAMINATION

1. LAST NAME - FIRST NAME - MIDDLE NAME <i>LEE Paul</i>			2. GRADE AND COMPONENT OF POSITION		3. IDENTIFICATION NO. <i>01656-087</i>
4. HOME ADDRESS (Number, street or RFD, city or town, State and ZIP Code)			5. PURPOSE OF EXAMINATION <i>Route Report</i>		6. DATE OF EXAMINATION <i>9-2-99</i>
7. SEX <i>M</i>	8. RACE <i>B</i>	9. TOTAL YEARS GOVERNMENT SERVICE MILITARY CIVILIAN		10. AGENCY <i>BOP</i>	11. ORGANIZATION UNIT
12. DATE OF BIRTH <i>4-11-53</i>		13. PLACE OF BIRTH		14. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN	
15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS <i>FCL - ALLENWOOD PO Box 2500 White Deer PA. 17887</i>				16. OTHER INFORMATION	
17. RATING OR SPECIALTY				TIME IN THIS CAPACITY (Total)	LAST SIX MONTHS

CLINICAL EVALUATION

NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary)

NOR- MAL	(Check each item in appropriate column, enter "NE" if not evaluated.)	ABNOR- MAL
<input checked="" type="checkbox"/>	18. HEAD, FACE, NECK AND SCALP	<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>	19. NOSE	
<input checked="" type="checkbox"/>	20. SINUSES	
<input checked="" type="checkbox"/>	21. MOUTH AND THROAT	
<input checked="" type="checkbox"/>	22. EARS - GENERAL (INTERNAL CANALS) (Auditory acuity under items 70 and 71)	
<input checked="" type="checkbox"/>	23. DRUMS (Perforation)	
<input checked="" type="checkbox"/>	24. EYES - GENERAL (Visual acuity and refraction under items 59, 60 and 67)	
<input checked="" type="checkbox"/>	25. OPHTHALMOSCOPIC	
<input checked="" type="checkbox"/>	26. PUPILS (Equality and reaction)	
<input checked="" type="checkbox"/>	27. OCULAR MOTILITY (Associated parallel movements, nystagmus)	
<input checked="" type="checkbox"/>	28. LUNGS AND CHEST (Include breasts)	
<input checked="" type="checkbox"/>	29. HEART (Thrust, size, rhythm, sounds)	
<input checked="" type="checkbox"/>	30. VASCULAR SYSTEM (Varicosities, etc.)	
<input checked="" type="checkbox"/>	31. ABDOMEN AND VISCERA (Include hernia)	
<input checked="" type="checkbox"/>	32. ANUS AND RECTUM (Hemorrhoids, fistulas) (Prostate, if indicated)	
<input checked="" type="checkbox"/>	33. ENDOCRINE SYSTEM	
<input checked="" type="checkbox"/>	34. G-U SYSTEM <i>NE</i>	
<input checked="" type="checkbox"/>	35. UPPER EXTREMITIES (Strength, range of motion)	
<input checked="" type="checkbox"/>	36. FEET	
<input checked="" type="checkbox"/>	37. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
<input checked="" type="checkbox"/>	38. SPINE, OTHER MUSCULOSKELETAL	
<input checked="" type="checkbox"/>	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
<input checked="" type="checkbox"/>	40. SKIN, LYMPHATICS	
<input checked="" type="checkbox"/>	41. NEUROLOGIC (Equilibrium tests under item 72)	
<input checked="" type="checkbox"/>	42. PSYCHIATRIC (Specify any personality deviation)	
<input checked="" type="checkbox"/>	43. PELVIC (Females only) (Check how done)	
	<input type="checkbox"/> VAGINAL <input type="checkbox"/> RECTAL	

Male pattern alopecia

PERUNG (2)

*Stably Acquired Umbilical Hernia
seen previously 8/99*

(Continue in item 73)

44. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)																REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES																																																																											
<table border="0"> <tr> <td colspan="4"> <table border="0"> <tr><td>0</td><td>1</td><td>2</td><td>3</td></tr> <tr><td>32</td><td>31</td><td>30</td><td>29</td></tr> <tr><td>0</td><td></td><td></td><td></td></tr> </table> </td> <td colspan="4"> <table border="0"> <tr><td>1</td><td>2</td><td>3</td></tr> <tr><td>32</td><td>31</td><td>30</td></tr> <tr><td>1</td><td></td><td></td></tr> </table> </td> <td colspan="4"> <table border="0"> <tr><td>Non-restorable teeth</td></tr> <tr><td>32 31 30</td></tr> <tr><td>1</td></tr> </table> </td> <td colspan="4"> <table border="0"> <tr><td>Missing Teeth</td></tr> <tr><td>32 31 30</td></tr> <tr><td>x</td></tr> </table> </td> <td colspan="4"> <table border="0"> <tr><td>Replaced by Dentures</td></tr> <tr><td>32 31 30</td></tr> <tr><td>x x x</td></tr> </table> </td> <td colspan="4"> <table border="0"> <tr><td>Fixed Partial dentures</td></tr> <tr><td>32 31 30</td></tr> <tr><td>(x)</td></tr> </table> </td> </tr> </table>																<table border="0"> <tr><td>0</td><td>1</td><td>2</td><td>3</td></tr> <tr><td>32</td><td>31</td><td>30</td><td>29</td></tr> <tr><td>0</td><td></td><td></td><td></td></tr> </table>				0	1	2	3	32	31	30	29	0				<table border="0"> <tr><td>1</td><td>2</td><td>3</td></tr> <tr><td>32</td><td>31</td><td>30</td></tr> <tr><td>1</td><td></td><td></td></tr> </table>				1	2	3	32	31	30	1			<table border="0"> <tr><td>Non-restorable teeth</td></tr> <tr><td>32 31 30</td></tr> <tr><td>1</td></tr> </table>				Non-restorable teeth	32 31 30	1	<table border="0"> <tr><td>Missing Teeth</td></tr> <tr><td>32 31 30</td></tr> <tr><td>x</td></tr> </table>				Missing Teeth	32 31 30	x	<table border="0"> <tr><td>Replaced by Dentures</td></tr> <tr><td>32 31 30</td></tr> <tr><td>x x x</td></tr> </table>				Replaced by Dentures	32 31 30	x x x	<table border="0"> <tr><td>Fixed Partial dentures</td></tr> <tr><td>32 31 30</td></tr> <tr><td>(x)</td></tr> </table>				Fixed Partial dentures	32 31 30	(x)																			
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LABORATORY FINDINGS

45. URINALYSIS: A. SPECIFIC GRAVITY		46. CHEST X-RAY (Place, date, film number and result)	
B. ALBUMIN	D. MICROSCOPIC		
C. SUGAR			
47. SEROLOGY (Specify test used and result)	48. EKG	49. BLOOD TYPE AND RH FACTOR	50. OTHER TESTS

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT 5'7"		52. WEIGHT 223		53. COLOR HAIR BLK		54. COLOR EYES BRN		55. BUILD: <input type="checkbox"/> SLENDER <input type="checkbox"/> MEDIUM <input checked="" type="checkbox"/> HEAVY <input type="checkbox"/> OBESE		56. TEMPERATURE					
57. BLOOD PRESSURE (Arm at heart level)						58. PULSE (Arm at heart level)									
A. SITTING SYS. 136 DAS. 86		B. AFTER EXERCISE SYS. 136 DAS. 86		C. 2 MIN. AFTER SYS. 136 DAS. 86		D. RECUMBENT SYS. 136 DAS. 86		E. AFTER STANDING 3 MIN. SYS. 136 DAS. 86							
59. DISTANT VISION				60. REFRACTION				61. NEAR VISION							
RIGHT 20/14E CORR. TO 20/				BY S. CX				CORR. TO 8Y							
LEFT 20/14E CORR. TO 20/				BY S. CX				CORR. TO 8Y							
62. HETEROPHORIA (Specify distance)															
ES°		EX°		R.H.		L.H.		PRISM DIV.		PRISM CONV. CT					
63. ACCOMMODATION				64. COLOR VISION (Test used and result)				65. DEPTH PERCEPTION (Test used and score)							
RIGHT LEFT								UNCORRECTED							
								CORRECTED							
66. FIELD OF VISION				67. NIGHT VISION (Test used and score)				68. RED LENS TEST							
								69. INTRAOCULAR TENSION							
70. HEARING				71. AUDIOMETER								72. PSYCHOLOGICAL AND PSYCHOMOTOR (Tests used and score)			
RIGHT WV /15 SV /15				250 500 1000 2000 3000 4000 6000 8000 256 512 1024 2048 2896 4096 6144 8192											
LEFT WV /15 SV /15				RIGHT											
				LEFT											
73. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY															

(Use additional sheets if necessary)

74. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with item numbers)

UMBILICAL HERNIA - REPAIRABLE
OBESITY
BPPV, TREATED 1995

75. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify)

77. EXAMINEE (Check)

A. ☒ IS QUALIFIED FORB. ☐ IS NOT QUALIFIED FOR

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

79. TYPED OR PRINTED NAME OF PHYSICIAN

R.J. Mayshock, PA-C

80. TYPED OR PRINTED NAME OF PHYSICIAN

81. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN (Indicate which)

82. TYPED OR PRINTED NAME OF EXAMINING PHYSICIAN (Indicate which)

ROBERT MUGLIORINO, D.O.

SIGNATURE

SIGNATURE

SIGNATURE

SIGNATURE

NUMBER OF ATTACHED SHEETS

FRAGILE

SEPH HUTTON
 FCI ALLENWOOD HEALTH SVC 654 01182
 RT 15 2 MI N OF ALLENWOOD
 WHITE DEER PA 17887-2500
 01656-087 LEE LI12

(FX) FEDERAL EXPRESS

UNICOR

JOSEPH HUTTON 01656-087 LEE LI12
 FCI ALLENWOOD HEALTH SVC
 RT 15 2 MI N OF ALLENWOOD
 WHITE DEER, PA 17887

SPHERE	CYLINDER	AXIS	Δ IN	Δ OUT	Δ UP	Δ DOWN	Δ
-1.50	-1.25	95					34.
-1.00	-.75	85					34.
SEGMENT							68.
6.00							4.0
ADD	HEIGHT	BASE CURVE	CENTER	EDGE	OSC.	DIST.	
		5.50			4.0		
SINGLE VISION COATED							6.00
LENS STYLE POLYCARBONATE LENS COLOR							SHO CLAS
SINGLE VISION COATED							5.50
INDUSTRIAL THICKNESS 3.0 MM							
BILLED TO ACCT 9991							
TOTAL RX PRICE							
USE FINISHED ONLY							

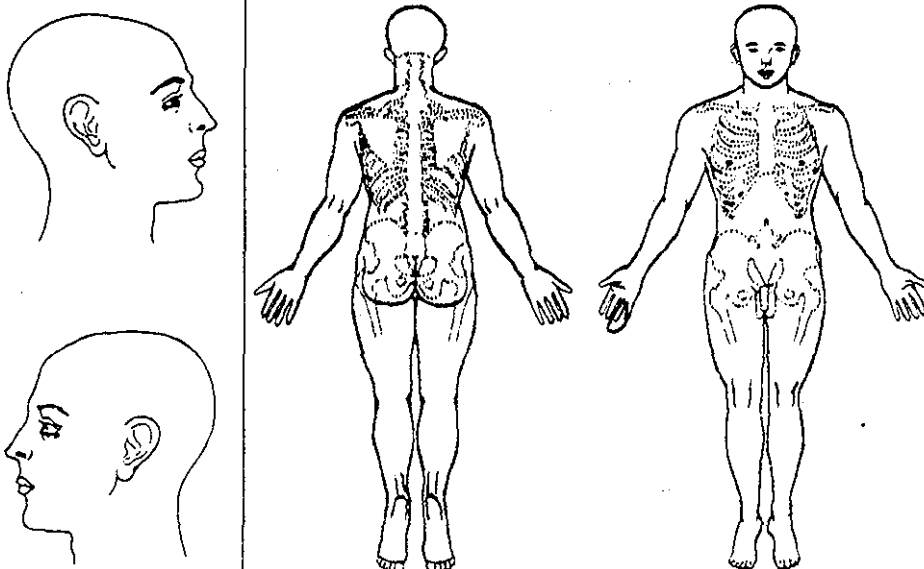
FRAME NAME	LAB SUPPLIED	SPACING	SPACING
SS 83-84	SMOKE		
SS	TEMP STYLE	TEMP COLOR	
24			
SS	TEMPLE STYLE SK ZYL	TEMPLE COLOR	
20	73-83-TN	SMOKE	

PATIENT NAME	DATE	TIME	REF
01656-087 LEE LI12			
H HUTTON	5502	08/30/99	1

SHIPPING ORDER

U.S. DEPARTMENT OF JUSTICE
Federal Bureau of Prisons

INMATE IN. ASSESSMENT AND FOLLOWUP
(Medical)

1. Institution FBI AUCHWOOD	2. Name of Injured LEE Paul	3. Register Number 01656-087
4. Injured's Duty Assignment FS AM	5. Housing Assignment 3B	6. Date and Time of Injury 8-13-99 1110
7. Where Did Injury Happen (Be specific as to location) FS DINING AREA	Work Related? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	8. Date and Time Reported for Treatment 8-13-99 1115
9. Subjective: (Injured's Statement as to How Injury Occurred)(Symptoms as Reported by Patient) CARRYING 2 BAGS OF PLASTIC CUPS - HADRA WALKING - CAUGHT SLEEPER IN NETER BOX & CUT ON 4TH FINGER ON PLASTIC CUP Signature of Patient		
10. Objective: (Observations or Findings from Examination) DEEP ABRASION ON 4TH FINGER DISTAL END @ NAIL ROOT AREA	X-Rays Taken _____ Not Indicated _____ X-Ray Results	
11. Assessment: (Analysis of Facts Based on Subjective and Objective Data) ABRASION		
12. Plan: (Diagnostic Procedures with Results, Treatment and Recommended Follow-up) ANTISEPTIC WASH - BANDAGE DRESSING - EDUCATE TO KEEP CLEAN & DRY - 2 GLOVES ISSUED		
13. This Injury Required: <input type="checkbox"/> a. No Medical Attention <input type="checkbox"/> b. Minor First Aid <input type="checkbox"/> c. Hospitalization <input checked="" type="checkbox"/> d. Other (explain) See 12 <input type="checkbox"/> e. Medically Unassigned <input type="checkbox"/> f. Civilian First Aid Only <input type="checkbox"/> g. Civilian Referred to Community Physician		
Signature of Physician or Physician Assistant [Signature] MASHAK PAK		

11-110

MEDICAL RECORD

CONSULTATION SHEET

REQUEST

FOR ALLENWOOD
PO Box 2500
White Deer PA. 17887

DATE OF REQUEST
4-26-99

Ortho Clinic

REASON FOR REQUEST

pt & hx. @ hip bursitis. States it is currently painful.
Exam shows ↓ ROM; point tenderness however no erythema or edema
was noted. Frays of @ hip ordered.

PROBABLE DIAGNOSIS

@ hip bursitis

DATE OF CONSULTATION

A. Marenich

RECORD PURCHASED

ROBERT MIGLIORINO, D.O.

CONSULTATION REPORT

UNDESIGNED

PLACE OF CONSULTATION

RECEIVED

DATE

ROUTINE

22 HOURS

TODAY

EMERGENCY

7-14-99 See the attached dictated note JTM/als

(Continue on reverse side)

SIGNATURE AND TITLE

IDENTIFICATION NO.

ORGANIZATION

REGISTERED

DATE

WARD NO.

PATIENT IDENTIFICATION (If typed or with a carbon copy Name Last, first, middle, grade, rank, rate, hospital or medical facility)

Lee Paul A.

LEE, PAUL A. -- 01656-087

7-14-99 Mr. Lee is 46 years old. He says that he never had any trouble with his hip before, but he has been having pain for a couple of years, while he has been in the system. There was no trauma beforehand. Overall he is healthy. He says that he takes no medication and that he has no blood problems, etcetera. At any rate, some x-rays were taken that show what is described as severe degenerative arthritis of the left hip. The x-rays are not available for my review today.

On examination today he flexes to about 90 degrees and then he has discomfort. Essentially he has no internal rotation from there. He comes to about neutral. He has about 15 degrees of external rotation. He flexes the same. Abduction is about 10 to 15 degrees less than that of his right hip.

I talked to him about using a cane. He tried ibuprofen in the past but that didn't seem to help. Perhaps the combination of the two will be of some value. He is awfully young to have a hip replacement, but that may be the best choice for him, depending upon how much pain he has. Certainly he would have to understand the risks of proceeding in that fashion. He complains of lateral-sided discomfort a little above the trochanteric area. We talked about an injection into the trochanteric area. He had one there a couple of years ago. He is sore just above the usual position for trochanteric bursitis. Mr. Lee does not want an injection. He does not want to use a cane.

I would be happy to review the films when they become available.

John T. Magill, III, M.D./als

cc: Health Services, FCI Allenwood

EM 8/11/99
ROBERT MIGLIORINO, D.O.

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
7/14/99 0935	S: Pt in for ORTHO Consult c Dr. Magill. O: Examined by DR. Magill. See consult sheet. A: DJD of @ Hip. P: Pt. instructed candidate for hip replacement in future. Offered cane and local injection. Which pt. refused. RTC - PRN. F. A. Terrero-Pena, MLP, PA
7/14/99 1700	ADMINISTRATIVE NOTE: PT. SEEN BY OPTOMETRY CONSULTANT. SEE CONSULT IN SECTION 2. Lee-Anne Whitmyre, HIT
7/28/99 1449	ADMINISTRATIVE NOTE: 7/28/99 per wrong chart written request by ITN a copy of medical records, excluding HIV results (16 copies) given to ITN via mail. Lee-Anne Whitmyre, HIT
8/13/99 1115	EP-362 (INMATE INJURY REPORT) COMPLETED ON THIS DATE. R.J. Mayshock, PA-C
8-18-99 1050	(5) Pt. requesting Prostate exam. Denies any symptoms, but wants it checked due to his age. (6) abd - round, soft, N.T. active B.S. K4. no masses. Rectal - no hemorrhoids, no enlargement of prostate, firm, non tender, no masses occult bld neg. (A) Pending prostate exam, no abnormalities found. (P) Dx: PSA ordered Rx: PSA PATIENT EDUCATION AND INSTRUCTION Patient: given and patient understands RTC: Per Lab. MA [Signature] PA-C

ATTACH 3D REPORT ALONG HERE ▲ AND SUCCEEDING ONES ON ABOVE LINES

ATTACH 2D REPORT WITH TOP AT THIS LINE ▲

— FILE 1 LINE —▲

BP-S622.060 RADIOLOGIC CONSULTATION REQUEST/REPORT CD/FRM
AUG 96

U.S. DEPARTMENT OF JUSTICE FEDERAL BUREAU OF PRISONS

Patient Identification Name, Register Number, Institution LEE, Paul 01656-087 4/11/53	Age 46	Sex M	EXAMINATION REQUESTED Chest	
	Pregnant <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	Requested by <i>H. Warrick</i>	Date Requested 7/2/99	
FCI ALLENWOOD, WHITE DEER, PA				

Specific reason(s) for request (Complaints and findings)

Hx. + PPD - annual examination

Date of examination 7/2/99	Date of Report 7/13/99	Date of Transcription 7/16/99	Film # 763-99
-------------------------------	---------------------------	----------------------------------	------------------

Radiologic Report

CHEST (SINGLE PA VIEW)

Normal heart and lungs. No pleural, hilar, or mediastinal abnormalities of significance noted. No radiographic changes suspicious of an active TB noted.

IMPRESSION: NORMAL.

Signature <i>[Signature]</i>	Location of Radiologic Facility FCI ALLENWOOD, WHITE DEER, PA.
---------------------------------	---

Original - Medical Record; Copy - Physician; Copy - Radiology
(This form may be replicated via WP)

Ray 7/16/99
ROBERT MCGLIORINO, D.O.

ic

30

ATTACH 3D REPORT ALONG HERE ▲ AND SUCCEEDING ONES ON ABOVE LINES

ATTACH 2D REPORT WITH TOP AT THIS LINE ▲

ATTACH 1ST REPORT ALONG LEFT MARGIN WITH TOP AT THIS LINE ▲

75622.060 RADIOLOGIC CONSULTATION REQUEST/REPORT COFRM
AUG 96

U.S. DEPARTMENT OF JUSTICE 41-11-53 FEDERAL BUREAU OF PRISONS

Patient Identification Name, Register Number, Institution <i>Lee, Paul A.</i> <i>016510-087</i>	Age <i>46</i>	Sex <i>M</i>	EXAMINATION REQUESTED <i>D hip</i>
	Pregnant <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
Requested by <i>D Deuge PA S / Mfg Date Requested</i>			<i>4-26-99</i>

Specific reason(s) for request (Complaints and findings)

<i>hx. D hip bursitis.</i>	Date of Report <i>6/23/99</i>	Date of Transcription <i>6/30/99</i>	Film # <i>634-99</i>
Date of examination <i>6/2/99</i>			

Radiologic Report LEFT HIP

There are no recent fractures nor dislocations. There are no lytic nor blastic lesions seen. Severe degenerative arthritis of the left hip joint is noted, with irregular narrowing of the joint space, cortical sclerosis, & marginal spur formation.

IMPRESSION: SEVERE DEGENERATIVE CHANGES OF THE LEFT HIP JOINT.

Signature *John M. Mc...* Location of Radiologic Facility *FCI ALLENWOOD, WHITE DEER, PA.* *W-30*

Original - Medical Record; Copy - Physician; Copy - Radiology
(This form may be replicated via WP)

DM 6/30/99
ROBERT MIGLIORINO, D.O.

NSN 7540-00-634-4176

800-

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)

4-30-99

①

unchanged from previous

cont:

②

1 URI - viral

③

PATIENT EDUCATION AND INSTRUCTION
GIVEN AND PT VERBALIZES UNDERSTANDING
ABOUT Don't get CMIS

from commissary

pt requests upill Actifed/Humabid

Request Denied Requests "little

yellow pills."

② RTC pin or 1/2 st worsen.

A. M. W.

Robert Mahenkoff, PA-C
Physician AssistantKee 3/3/99
ROBERT MIGLIORINO, D.O.

D. Duge PH-S

DAWN DUGE

6-23-99

1545

Admin note: Patient did not show for sick call appt.

M. Anthony Bryant, PA-C

7-6-99

1245

S. Pt. here to discuss x-ray result.

O. no exam done

A. DJS ③ Hip

Rt. Ed. ... DJS explained to pt. =

various Tx options.

Explained that he will see orthopedic

specialist

Pt. agrees & understands

A. Mahenkoff PA-C

Robert Mahenkoff, PA-C
Physician Assistant

PATIENT'S IDENTIFICATION (Use this space for Mechanical Imprint)

RECORDS
MAINTAINED
AT:

PATIENT'S NAME (Last, First, Middle initial)

SEX

RELATIONSHIP TO SPONSOR

STATUS

RANK/GRADE

SPONSOR'S NAME

ORGANIZATION

DEPART./SERVICE

SSN/IDENTIFICATION NO.

DATE OF BIRTH

01656-087

4-11-53

FCI Allenwood

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTC	DIAGNOSIS, TREATMENT, TREATING OF	NIZATION (Sign each entry)
4-26-99 1440	<p>⑤/ Pt. c/o nasal d/c (white) & congestion & cough & sputum. Also c/o hernia & hx. ④ hip bursitis</p> <p>⑥/ T 97.6°F</p> <p><u>HEENT</u>: NC/AT @ sinus tenderness; PERRLA / EDML Ed/c. CANALS clear, TM's gray & light reflex / ANDMARKS turbinates inflamed & white d/c. Throat patent & mild erythema @ PND. <u>NECK</u>: Lymphadenopathy. <u>LUNGS</u>: CTAB @ 3 Adventitia. <u>CV</u>: RRR. <u>ABD</u>: Soft/round NT/ND @ organomegaly. @ umbilical hernia - reducible & strangulation/ incarceration. <u>④ hip</u>: ↓ ROM all fields, @ point tenderness over joint @ erythema or signs of active inflammation.</p> <p>①/ 1 URI - viral</p> <p>2. Umbilical hernia</p> <p>3. @ hip bursitis by hx.</p>	<p>⑥/ Rx: Humabid $\dot{\bar{i}}$ po BID x 5d.</p> <p>Actifed $\dot{\bar{i}}$ po TID x 5d.</p> <p>Mohr 400mg $\dot{\bar{i}}$ - $\dot{\bar{i}}$ q 10-8° or prn for pain x 10d</p> <p>X-rays: 4-ray @ hip</p>	<p>M. Potter, Rph. Pharmacist</p> <p>PATIENT EDUCATION AND INSTRUCTION GIVEN AND PT VERBALIZES UNDERSTANDING ABOUT: <u>④ Debridement</u></p> <p>② meds & side effects</p> <p>③ f/u: RTA pin</p> <p>④ consult for ortho written</p> <p>R. Manenoff, PA-C Physician Assistant</p> <p>J. Kiege PA-C Dr. D. D. D.</p>
4-30-99 1300	<p>⑤/ "The medication you gave me is not working."</p> <p>Pt. still @ white nasal d/c, congestion, cough.</p> <p>Medicines will run out tomorrow.</p> <p>Pt. denies any Δ in sx or severity (cont)</p>		

NSN 7540-00-634-4176

600-108

HEALTH RECORD

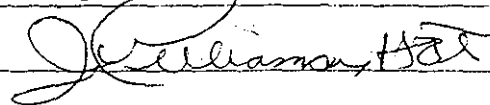
CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE

SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)

INMATE ARRIVED FCI ALLENWOOD ON 11-16-98 AT 2022 HOURS - TRANSFER FROM FCI BECKLEY.

J. WILLIAMSON, HIT



4-19-99

1110

⑤ Patient c/o, "my glasses are causing dark places under my eyes". States glasses were prescribed at FCI Beckley when his personal ^{2.100 MAG 41941} glasses were found, "not to be strong enough." Optometry prescribed current glasses & frames. States "The officers keep asking me who hit me in the eye."

⑥ Eyes - PERRLA, EOM's intact. Lower orbits show hyperpigmentation with the pattern of the frame clearly visible. Orbit is nontender to palpation, & edema is noted.

⑦ Hypopigmentation of skin of lower orbits. R/O hypersensitivity to frame of glasses.

⑧ OX: Optometry consult to re-evaluate prescription and install lenses into personal frames.

Rx: Ø

Pat ed: PATIENT EDUCATION AND INSTRUCTION
GIVEN AND PT VERBALIZES UNDERSTANDING
ABOUT optometry consult.

wear glasses only when working
as needed until seen by optometry.

RTC: PRN or per optometry appt.

MA 4/19/99
ROBERT MISCIORINO, D.O.

MA Bryant, PA-C

PATIENT'S IDENTIFICATION (Use this space for Mechanical Imprint)

RECORDS
MAINTAINED
AT:

PATIENT'S NAME (Last, First, Middle initial)

LEE, PAUL A

SEX

M

RELATIONSHIP TO SPONSOR

STATUS

RANK/GRADE

SPONSOR'S NAME

ORGANIZATION

DEPART./SERVICE SSN/IDENTIFICATION NO.

01656-087

DATE OF BIRTH

4-11-53

FCI - ALLENWOOD
PO Box 2500
White Deer PA, 17887

A & O EXAMINATION - WEEK OF _____

Inmate Name: LEE, PAULReg. No. 01656-087

Medical Duty Status:

Clinics: (check next due date)

Allergic to Wool
 No Sports/No Weight Lifting
 No Excess Cold/Wind
 Glasses Required for Driving
 No Work in High Noise Areas
 No Ladders/No Upper Bunk
 No Excess Sun
 Lower Bunk Required
 No Driving-Medical Condition
 No Duty Due to Medical Condition
 No Food Service
 Pollution Free Area
 Not Medically Cleared
 Orthopedic Shoes
☒ Regular Duty-No Restrictions ✓
☐ Regular Duty With Restrictions
 Soft Shoes
☐ Special Diet-Medical Condition
☐ No Prolonged Standing
☐ No Lifting Over 15 lb.
☐ No Lifting Over 20 lb.
☐ No Lifting Over 25 lb.
☒ Cleared For Food Service ✓
 Other Comments: _____

Hypertension
 Cardiac
 Pulmonary
 Diabetic
 General
 Infectious Disease
 Mental Health

**Disabilities: (note disability
 and any necessary
 accommodations)**

PPD Status:

Date of Last PPD 3-10-95 ✓
 Last PPD Result +15 mm ✓

If Positive PPD:

Date of Last CXR 7-1-98 ✓
 TB Prophyl Code: 795.5 B ✓
 TB Prophyl Dates 10-20-95 ✓
 (may be by hx or n/a)

Practitioner's Initials: MToday's Date: 11-27-98Chart /MDS's / SMD's Reviewed: ROBERTO MIGLIORINO, D.O.

Clinical Director's Signature

FCI Allenwood
 P. O. Box 2500
 White Deer, PA 17887

**please place this file in
 Dr.'s box if signature is
 needed on physical exam

CURRENT STATUS (PER SENTRY) ARE HIGHLIGHTED
 PLEASE REVIEW CHART FOR APPROVAL OR CHANGES

BP-S354.060 INTAKE SCREENING (MEDICAL) CDFRM
NOV 94

U.S. DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF PRISONS

(Medical staff shall complete this screening form on all arrivals to the Institution)

Institution FCI-ALM	Date of Arrival 11-16-98	Time of Arrival 1830
Inmate's Name Lee, Paul	Register Number 01656-087	

M E D I C A L C L E A R A N C E

1. BP-149(60) reviewed? ☒ yes; ☐ no (Explain)
2. General Population Housing Approved? ☒ yes; ☐ no (Specify limitation or need)
3. Approved for Temporary Work Assignment? ☐ yes; ☒ no (Specify limitations or exclusions)
no barbershop, food service/or hospital until cleared by PA.
4. For Holdovers: OK for Continued Transport? ☒ yes; ☐ no (Explain)
5. Disabilities? ☐ yes ☒ no (If yes, enter code(s) into MDS)
Code(s)

6. Remarks:

Medical Staff Signature, RN Gloria L. Lantz RN	Date 11-16-98	Time 1945
Medical Staff Title Registered Nurse		

Record Copy - Inmate Central File; copy - file
(This form may be replicated via WP)Replaces BP-354(60) of APRIL 1990
and BP-S354 of AUG 1994

U.S. Department of Justice
Federal Bureau Of Prisons

MEDICAL HISTORY REPORT

(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY
AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME—FIRST NAME—MIDDLE NAME <u>Lee Pau A</u>		2. REGISTER NUMBER <u>01656-087</u>
3. PURPOSE OF EXAMINATION <u>intake screening</u>	4. DATE OF EXAMINATION <u>11-16-98</u>	5. EXAMINING FACILITY <u>FCI-ALM</u>
6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Follow by description of past history, if complaint arises) <u>"Good"</u> <u>8 meds</u>		

7. HAVE YOU EVER (Please check each item)		8. DO YOU (Please check each item)	
YES	NO	YES	NO
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
(Check each item)		(Check each item)	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Lived with anyone who had tuberculosis		Wear glasses or contact lenses	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Coughed up blood		Have vision in both eyes	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Bled excessively after injury or tooth extraction		Wear a hearing aid	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Attempted suicide		Stutter or stammer habitually	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Been a sleepwalker		Wear a brace or back support	

9. HAVE YOU EVER HAD OR HAVE YOU NOW (Please check at left of each item)											
YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet fever	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Adverse reaction to serum drug or medicine	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or fits
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Broken bones	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Car, train, sea or air sickness
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Swollen or painful joints	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tumor, growth, cyst, cancer	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent trouble sleeping
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent or severe headache	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rupture/hernia	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Depression or excessive worry
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness or fainting spells	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Piles or rectal disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of memory or amnesia
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eye trouble	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent or painful urination	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nervous trouble of any sort
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ear, nose, or throat trouble	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bed wetting since age 12	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Periods of unconsciousness
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stone or blood in urine	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had homosexual contact?
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic or frequent colds	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sugar or albumin in urine	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Been exposed to AIDS
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Severe tooth or gum trouble	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	VD—Syphilis, gonorrhea, etc.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Use (Excessive)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sinusitis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recent gain or loss of weight	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drug Use/Addiction
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis, Rheumatism, or Bursitis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Marijuana
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Head injury	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bone, joint or other deformity	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cocaine
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin diseases	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lameness	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heroin
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid trouble	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Loss of finger or toe	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	L.S.D.
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Painful or "Trick" shoulder or elbow	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Amphetamines
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent back pain	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Others: (Specify)
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	"Trick" or locked knee	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol or drug
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pain or pressure in chest	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Foot trouble	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Withdrawal Problems
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neuritis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Palpitation or pounding heart	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis (include infantile)	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart trouble	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High or low blood pressure	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cramps in your legs	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent indigestion	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stomach, liver, or intestinal trouble	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder trouble or gallstones	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice or hepatitis	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

11. WHAT IS YOUR USUAL OCCUPATION?

12. ARE YOU (Check one)

☐ Right handed ☐ Left

CHECK EACH ITEM YES OR NO EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE BELOW			
YES	NO		
	<input checked="" type="checkbox"/>	13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.	
	<input checked="" type="checkbox"/>	B. Inability to perform certain motions.	
	<input checked="" type="checkbox"/>	C. Inability to assume certain positions.	
	<input checked="" type="checkbox"/>	D. Other medical reasons (If yes, give reasons.)	
	<input checked="" type="checkbox"/>	14. Have you, ever been treated for a mental condition? (If yes, specify when, where, and give details.)	
	<input checked="" type="checkbox"/>	15. Have you ever been denied life insurance? (If yes, state reason and give details.)	
	<input checked="" type="checkbox"/>	16. Have you had, or have you been advised to have, any operations? (If yes, describe and give age at which occurred.)	
	<input checked="" type="checkbox"/>	17. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)	
	<input checked="" type="checkbox"/>	18. Have you ever had any illness or injury other than those already noted? (If yes, specify when, where, and give details.)	
	<input checked="" type="checkbox"/>	19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)	
	<input checked="" type="checkbox"/>	20. Have you ever been rejected for military service because of physical, mental, or other reason? (If yes, give date, and reason, for rejections.)	
	<input checked="" type="checkbox"/>	21. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)	
	<input checked="" type="checkbox"/>	22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? (If yes, specify what kind, granted by whom, and what amount, when, why.)	

EXPLANATION: (#13-22 ABOVE)

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record.

TYPED OR PRINTED NAME OF EXAMINEE

SIGNATURE

INTAKE SCREENING:

INMATE RECEIVED FROM: COURT _____ TRANSFER ☒ P.V. _____

OTHER _____

THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF DRUGS OR ALCOHOL? _____

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE MEDICAL STAFF YES _____ NO ☒

WHAT ARRANGEMENTS HAVE BEEN MADE? _____

DUTY STATUS: TEMPORARY WORK ☒ RESTRICTED _____GENERAL POPULATION ☒ YES _____ NO _____

TYPE AND EXTENT OF LIMITATION _____

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL SUICIDE, APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS, RASHES, JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY DEFORMITIES, ETC. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

IF DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW MUCH, HOW OFTEN, HOW USED. WHEN WERE THEY LAST USED: HAVE

23. Physician's summary and elaboration of all pertinent data (Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)

① Hearing loss (L) ear.
② (L) hip bursitis

TYPED OR PRINTED NAME OF PHYSICIAN OR

DATE

SIGNATURE

NUMBER OF ATTACHED SHEETS

500-108

11/2/98 S. have (L) hip art hrt 5
0842 need pain med
NKA O+A hip pain by hx
P Motrin 800 TID prn X300
Edre dx to Rx c comp Done

DATE OF BIRTH

CHRONOLOGICAL RECORD OF MEDICAL CARE ST/ 48

BP-S354.060 INTAKE SCREENING (MEDICAL) CDFRM

NOV 94

U.S. DEPARTMENT OF JUSTICE

(Medical staff shall complete this so
Institution)

Institution

Date of

Inmate's Name

LEE

PAUL A

01656-087

B/M/O/04-11-1953

HT/508WT/205HR/BKEY/BN

CUSTODY/IN

M E D I C A L

1. BP-149(60) reviewed? ☒ yes; ☐ no (Explain)2. General Population Housing Approved? ☒ yes; ☐ no (Specify limitation or
need)3. Approved for Temporary Work Assignment? ☒ yes; ☐ no (Specify limitations
or exclusions)4. For Holdovers: OK for Continued Transport? ☒ yes; ☐ no (Explain)5. Disabilities? ☐ yes ☒ no (If yes, enter code(s) into MDS)
Code(s)

6. Remarks:

Medical Staff Signature

Date

OCT 26 1998

Time

Medical Staff Title

Brian Cronenwett, LT.
Registered Nurse
Federal Transfer Center, OKC, OKRecord Copy - Inmate Central File; copy 2 file
(This form may be replicated via WP)Replaces BP-354(60) of APRIL 1990
and BP-S354 of AUG 1994

BP-S149.060 MEDICAL RECORD OF FEDERAL PRISONER IN TRANSIT CDFRM

JUL 96

U.S. DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF PRISONS

TB Clearance PPD Completed: <u>3/10/98</u> Date Results: <u>15</u> mm Interpreted as: <u>POS</u> (Positive or Negative) CXR Completed: <u>7/1/98</u> (Date) Results: <u>WNL</u> Note: Date(s) listed above must be within one year of this transfer.		Name: <u>Lee, Paul</u> Reg. No. <u>01656-087</u> Departed From: <u>FCI Beckley</u> Date Departed: <u>10/28/98</u> Destination: <u>ALM</u> Reason for Transfer: <u>WORK-MEDICAL</u> Name of Institution Special Instructions: <u>Blood and Body Fluid Precautions</u> <u>NO KNOWN ALLERGIES</u> Diagnoses: 1. <u>Hx. (+) TBC</u> 4. 2. <u>ESSENTIALLY HEALTHY UNCLE</u> 3. 6.	
--	--	--	--

No inmate may be transferred to any BOP facility unless either PPD or CXR results are satisfactory for medical clearance.

MEDICATION FOR CARE ENROUTE

Medication	Dose	Route	Instructions for Use (Include proper time for administering)	Stop
<u>NONE</u>				

Signature of Certifying Medical Staff Member

Title

Date Signed

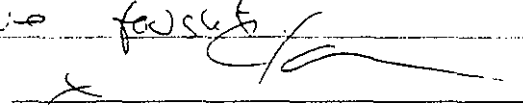
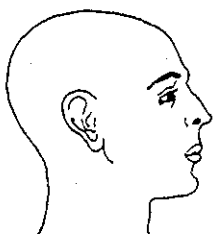
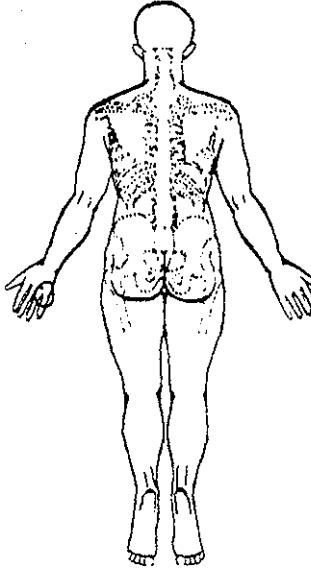
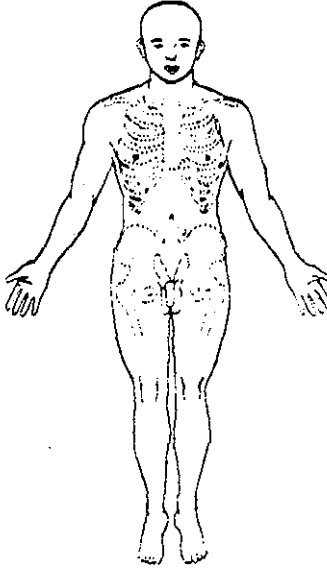
[Signature] ESSENTIALVA10/27/98

PROGRESS NOTES ENROUTE

Date	Time	Institution	Symptoms, Findings, Medications, Treatment, Order, Etc.
<u>10/27/98</u>	<u>1400</u>	<u>FBI OKC</u>	<u>OKC. FOR TRANSFER. [Signature]</u>
Federal Transfer Center Oklahoma City, OK Date <u>OCT 28 1998</u> Medication: Yes <u> </u> No <u> </u> Hot Meds: Yes <u> </u> No <u> </u> Meds Issued: Yes <u> </u> No <u> </u> Lice Seen: Yes <u> </u> No <u> </u> Signature & Stamp Brian Cronenwett, LT. Registered Nurse Federal Transfer Center, OKC, OK		Food or Drug Allergies: <u>NKA: Allergies:</u> Current Medical Status: <u>No Complaints; Complaint of</u> TB Signs and Symptom (s) <u>NONE:</u> cough, hemoptysis, night sweats, wt. loss MEDICATION TIMES once daily = 8:00 am 2x daily = 8:00 am 5:00 pm 3x daily = 8:00 am 12:00 pm 5:00 pm 4x daily = 8:00 am 12:00 pm 3:00 pm 8:00 pm C. [Signature] NOV 13 1998 11-6-98 1945 FCI-ALM reviewed BP 360/211 Emergent CIO presently lice seen. Attach SF-600 if additional space is required. <u>[Signature]</u>	

U.S. DEPARTMENT OF JUSTICE
Federal Bureau of Prisons

INMATE INJURY ASSESSMENT AND FOLLOWUP
(Medical)

1. Institution <i>ELI BETHLEY</i>		2. Name of Injured <i>Lee, Paul</i>		3. Register Number <i>01656087</i>	
4. Injured's Duty Assignment <i>Food Service</i>		5. Housing Assignment <i>Volar Upper</i>		6. Date and Time of Injury <i>8/25/98 0600</i>	
7. Where Did Injury Happen (Be specific as to location) <i>Food Service, back room</i>		Work Related? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		8. Date and Time Reported for Treatment <i>8/25/98 0645</i>	
9. Subjective: (Injured's Statement as to How Injury Occurred)(Symptoms as Reported by Patient) <i>"The guy said something I did not like and we fought"</i> 					
10. Objective: (Observations or Findings from Examination) <i>1st runner, bleeding</i>		X-Rays Taken <input type="checkbox"/> Not Indicated <input checked="" type="checkbox"/> X-Ray Results			
<i>laceration site near acromioclavicular joint. FROAR, no edema</i>					
11. Assessment: (Analysis of Facts Based on Subjective and Objective Data) <i>① minor laceration 879.6(A) ② Confusion</i>					
12. Plan: (Diagnostic Procedures with Results, Treatment and Recommended Follow-up) <i>① Triple antibiotic twice a day ② Keep wound dry & clean</i>					
13. This Injury Required: <input type="checkbox"/> a. No Medical Attention <input checked="" type="checkbox"/> b. Minor First Aid <input type="checkbox"/> c. Hospitalization <input type="checkbox"/> d. Other (explain) <input type="checkbox"/> e. Medically Unassigned <input type="checkbox"/> f. Civilian First Aid Only <input type="checkbox"/> g. Civilian Referred to Community Physician <i>E. SCHIP, MD</i> Signature of Physician or Physician Assistant		  			

Original - Medical File

Canary - Safety

Pink - Work Supervisor (Work related only)

Goldenrod - Correctional Supervisor

Self Carboned Form - If ballpoint pen is used, PRESS HARD

NSN 7540-00-834-4176

HEALTH RECORD		CHRONOLOGICAL RECORD OF MEDICAL CARE	
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)		
8/24/96	0905. NB / Show S/C 0830 Appointment / E. Blankenship		
9-15-98	S - See GROW CONSULT 7-24-98. WOULD LIKE STEROID INJECTION		
0730	O - DEFERR		
SHA	A - PIRIFORMIS SYNDROME		
	P4E - ① INDIAN 25 MG T TIO PL #21		
	② RE-INITIATE CONSULT		
	P. D. [Signature]		

PATIENT'S IDENTIFICATION (Use this space for Mechanical Imprint)

Federal Correctional Institution
P.O. Box 1980
Rever, WV 25812

RECORDS
MAINTAINED
AT:

PATIENT'S NAME (Last, First, Middle Initial)

L. Y. Paul

RELATIONSHIP TO SPONSOR

STATUS

SEX

RANK/GRADE

SPONSOR'S NAME

ORGANIZATION

DEPART./SERVICE

SSN/IDENTIFICATION NO.

DATE OF BIRTH

DATE	SYMPTOM	DIAGNOSIS, TREATMENT, TREATING OF	NIZATION (Sign each entry)
7.24.98	S - #1 UMBILICAL HERNIA #2 (C) HIP PAIN - SEE ORTHO CONSULT OF		
OSHO			
T-98.8			
P-80	O - 3.5cm UMBILICAL HERNIA, REDUCIBLE 3 R.S.		
P-12	A - UMBILICAL HERNIA - NON INCARCERATED		
R/P 136/82		PIRIFORMIS SYNDROME	
		PTS - (1) NO TX FOR HERNIA NEEDED (2) PT COLLAPSED RE: HERNIA INCARCERATION. (3) REFER TO DR. BATEMAN FOR STEROID INJECTION CONSIDERATION. (4) NO NEED FOR LOW BACK. (5) INDOXIN 25. TMD PC #21 R+1 PD	
			P. Diambra PA
8.14.98	S: "I have a boil"		
Hr-87	O: On exam vit. has an infected hair follicle on inner thigh		
BP-158/84			
T-98.8			
OSHO	A: Boil		
		V. C. Keflex 500 TID 1310 H 20	
		(6) Indocin 25 TID 15	
		(7) Educated about Tx.	
			E.J. CRIST, PA

513-110

NSN 7540-00-034-412

MEDICAL RECORD

CONSULTATION SHEET

REQUEST

TO <u>ORTHO</u>	FROM: (Requesting physician or activity) <u>FCI MED</u>	DATE OF REQUEST <u>7-24-98</u>
--------------------	--	-----------------------------------

REASON FOR REQUEST (Complaints and findings)

REFER TO YOUR CONSULT OF 5-4-97. S+S RETURNING. PT WOULD
LIKE ANOTHER STEROID INJECTION.

PROVISIONAL DIAGNOSIS

PIRIFORMIS SYNDROME

DOCTOR'S SIGNATURE

[Signature] **P. Diambra PA**

APPROVED

REGON-RIVERA
BECKLEY

PLACE OF CONSULTATION

☐ BEDSIDE☐ ON CALL☐ ROUTINE☐ TODAY☐ 72 HOURS☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NOPATIENT EXAMINED ☐ YES ☐ NO

13001
12:30 Appointment
NO Show
JA Blaylock

(Continue on reverse side)

SIGNATURE AND TITLE

DATE

IDENTIFICATION NO.

ORGANIZATION

REGISTER NO.

WARD NO.

PATIENT

PAUL A

01656-007

to: rank; rate; hospital or medical facility)

B/M/O/04-11-1953

HT/508

WT/205

HR/BK

EY/BN

CUSTODY/IN

CONSULTATION SHEET

Medical Record

RADIOLOGIC CONSULTATION REQUESTS/REPORTS

MEDICAL RECORD

#10714

BP-3622.060 RADIOLOGIC CONSULTATION REQUEST/REPORT CDFRM
 AUG 96
 U.S. DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF PRISONS

Patient Identification Name, Registration Number, Institution <i>del, Paul</i>	Age <i>35 M</i>	SEX <i>M</i>	EXAMINATION REQUESTED <i>CXR</i>
Pregnant C Yes C No	Requested by		
Date Requested		Date Requested	

Specific reason(s) for request (Complaints and findings)

Physical

Date of examination <i>7/1/98</i>	Date of Report <i>7/8/98</i>	Date of Transcription	Film #
--------------------------------------	---------------------------------	-----------------------	--------

Radiologic Report

CHEST: The heart size, mediastinum and both hila appear normal. Both lungs are fully expanded and essentially clear. There is no evidence of congestion or active pulmonary infiltrates. The bony thorax and diaphragm are unremarkable as noted.

IMPRESSION: Essentially negative chest.

Signature

[Signature]
 Location of Radiologic Facility
 DR L NEGRON RIVERA
 FPC/FCI RECKLEY

Original - Medical Record: *[Signature]* Physician: Copy to Radiology
 (This form may be reutilized via WP)



Form 30-100 (Rev. 8-83)

SIGNATURE

STANDARD FORM 519-A (REV. 8-83)

NSN 7540-01-034-4176

HEALTH RECORD		CHRONOLOGICAL RECORD OF MEDICAL CARE	
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)		
5-14-98	S. BP 128/82 HR 77 T. 97.2		
0855	S. C/o Pain (D) elbow & started last wk - in activity while rolling in		
	C - (D) Elbow pain to palpation over the distal 3rd joint across the elbow flexor		
	Supracondylar flexor muscle -		
	proximal Supinator etc.		
	A (D) Splashed skin		
	P - moxif 400 to 28 2 tabs after breakfast & supper - b.i.d.		
	C/o no more pain + no more		
	E. ROBERTS, PA		
	S. Dittert, Rph		
5/22/98	I have a bad cold that my chest is hurting		
0857	a Pt now 45 1/6 blood to examination after started last week		
T 100.3	actually show some 1/2 hrs bulging nose clear discharge		
P. 76	lungs clear P-A throat: red & injected & places		
Nei 14-A	URI (strep-throat)		
158/46	Anaxal sooty T 10 T 50 A 30		
	① CT scan T 10 B 20 A 20		
	② Tylenol sooty T 10 94-6 hrs PRN fever # 20		
	③ Advice to T 10/ Advise 5-10 hrs and give 600 mg & warm salt water		
	④ ATC for one week & re-evaluate or in 1 week		
PATIENT'S IDENTIFICATION (Use this space for Mechanical Imprint)		RT LEE	
FEDERAL CORRECTIONAL INSTITUTION, PA		MAI PAUL A 01656-087	
P.O. Box 1280		PAT B/M/O/04-11-1953	
Beaver, WV 25813		HT/508 WT/205 HR/BK EY/BN	
		REL CUSTODY/IN	
		SPOI	
		DEP.	
		SEX	
		RANK/GRADE	
		TION	
		DATE OF BIRTH	

REPORT OF MEDICAL EXAMINATION

1. LAST NAME - FIRST NAME - MIDDLE NAME <i>Lee, Paul</i>		2. GRADE AND COMPONENT OR POSITION	3. IDENTIFICATION NO. <i>01656-087</i>
4. HOME ADDRESS (Number, street or RFD, city or town, State and ZIP Code) <i>17-163 6. V. m. W. H. 16002</i>		5. PURPOSE OF EXAMINATION <i>A+C</i>	6. DATE OF EXAMINATION <i>3-15-95</i>
7. SEX <i>M</i>	8. RACE <i>W</i>	9. TOTAL YEARS GOVERNMENT SERVICE MILITARY CIVILIAN	10. AGENCY <i>BOP</i>
11. ORGANIZATION UNIT <i>FCZ McKean</i>		12. NAME, RELATIONSHIP, AND ADDRESS OF NEXT OF KIN <i>Paula Lee</i>	
13. DATE OF BIRTH <i>4-11-53</i>		14. PLACE OF BIRTH <i>Lee, Pa</i>	
15. EXAMINING FACILITY OR EXAMINER, AND ADDRESS <i>P.O. Box 5000, Bradford, PA 16701</i>		16. OTHER INFORMATION	
17. RATING OR SPECIALTY		TIME IN THIS CAPACITY (Total) LAST SIX MONTHS	

CLINICAL EVALUATION		ABNOR- MAL
NOR- MAL	(Check each item in appropriate column, enter "NE" if not evaluated)	
<input checked="" type="checkbox"/>	18. HEAD, FACE, NECK AND SCALP	
<input checked="" type="checkbox"/>	19. NOSE	
<input checked="" type="checkbox"/>	20. SINUSES	
<input checked="" type="checkbox"/>	21. MOUTH AND THROAT	
<input checked="" type="checkbox"/>	22. EARS - GENERAL (INTERNAL CANALS) (Auditory acuity under items 70 and 71)	
<input checked="" type="checkbox"/>	23. DRUMS (Perforation)	
<input checked="" type="checkbox"/>	24. EYES - GENERAL (Visual acuity and refraction under items 59, 60 and 67)	
<input checked="" type="checkbox"/>	25. OPHTHALMOSCOPIC	
<input checked="" type="checkbox"/>	26. PUPILS (Equality and reaction)	
<input checked="" type="checkbox"/>	27. OCULAR MOTILITY (Associated parallel movements, nystagmus)	
<input checked="" type="checkbox"/>	28. LUNGS AND CHEST (Include breasts)	
<input checked="" type="checkbox"/>	29. HEART (Thrust, size, rhythm, sounds)	
<input checked="" type="checkbox"/>	30. VASCULAR SYSTEM (Varicosities, etc.)	
<input checked="" type="checkbox"/>	31. ABDOMEN AND VISCERA (Include hernia)	
<input checked="" type="checkbox"/>	32. ANUS AND RECTUM (Hemorrhoids, Fissures) (Prostate, if indicated)	
<input checked="" type="checkbox"/>	33. ENDOCRINE SYSTEM	
<input checked="" type="checkbox"/>	34. G-U SYSTEM	
<input checked="" type="checkbox"/>	35. UPPER EXTREMITIES (Strength, range of motion)	
<input checked="" type="checkbox"/>	36. FEET	
<input checked="" type="checkbox"/>	37. LOWER EXTREMITIES (Except feet) (Strength, range of motion)	
<input checked="" type="checkbox"/>	38. SPINE, OTHER MUSCULOSKELETAL	
<input checked="" type="checkbox"/>	39. IDENTIFYING BODY MARKS, SCARS, TATTOOS	
<input checked="" type="checkbox"/>	40. SKIN, LYMPHATICS	
<input checked="" type="checkbox"/>	41. NEUROLOGIC (Equilibrium tests under item 72)	
<input checked="" type="checkbox"/>	42. PSYCHIATRIC (Specify any personality deviation)	
<input checked="" type="checkbox"/>	43. PELVIC (Females only) (Check how done) <input type="checkbox"/> VAGINAL <input type="checkbox"/> RECTAL	

NOTES: (Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary)

② side partially occluded with wound - visualization difficult / no obvious abnormality

PERSLA

clear & rhonchi, wheezes
RRR without murmur

no edema, chemo. ② umbilical hernia - markedly
depressed

see anatomical figure
dry skin on lower extremities

(Continue in item 73)

44. DENTAL (Place appropriate symbols, shown in examples, above or below number of upper and lower teeth.)																REMARKS AND ADDITIONAL DENTAL DEFECTS AND DISEASES																																											
<table border="0"> <tr> <td>0</td><td>1</td><td>2</td><td>3</td><td>Restorable</td> <td>1</td><td>2</td><td>3</td><td>Non-restorable</td> <td>1</td><td>2</td><td>3</td><td>Missing</td> <td>1</td><td>2</td><td>3</td><td>Replaced by Dentures</td> <td>1</td><td>2</td><td>3</td><td>Fixed Partial dentures</td> </tr> <tr> <td>32</td><td>31</td><td>30</td><td></td><td>Teeth</td> <td>32</td><td>31</td><td>30</td><td>Teeth</td> <td>32</td><td>31</td><td>30</td><td>Teeth</td> <td>32</td><td>31</td><td>30</td><td>Teeth</td> <td>32</td><td>31</td><td>30</td><td>Teeth</td> </tr> </table>																0	1	2	3	Restorable	1	2	3	Non-restorable	1	2	3	Missing	1	2	3	Replaced by Dentures	1	2	3	Fixed Partial dentures	32	31	30		Teeth	32	31	30	Teeth	32	31	30	Teeth	32	31	30	Teeth	32	31	30	Teeth		
0	1	2	3	Restorable	1	2	3	Non-restorable	1	2	3	Missing	1	2	3	Replaced by Dentures	1	2	3	Fixed Partial dentures																																							
32	31	30		Teeth	32	31	30	Teeth	32	31	30	Teeth	32	31	30	Teeth	32	31	30	Teeth																																							
R	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	L																																										
I	32	31	30	29	28	27	26	25	24	23	22	21	20	19	18	17	E																																										
G																	F																																										
H																	T																																										
T																																																											

LABORATORY FINDINGS

45. URINALYSIS: A. SPECIFIC GRAVITY		46. CHEST X-RAY (Place, date, film number and result)	
B. ALBUMIN	D. MICROSCOPIC		
C. SUGAR			
47. SEROLOGY (Specify test used and result)	48. EKG	49. BLOOD TYPE AND RH FACTOR	50. OTHER TESTS

DEC. 12. 1997 12:29PM P 3

FROM : Panasonic PPF

513 110

NSN 7540-00-634-4127

MEDICAL RECORD

CONSULTATION SHEET

REQUEST

FROM: (Requesting physician or activity)

DATE OF REQUEST

REASON FOR REQUEST (Consultation or referral)

Betts

8-4-97

PROVISIONAL DIAGNOSIS

Bot is greater troch. Bursitis hip.
 Pain is centered above when
 Tension greater troch
 Pain is from internal rotation
 Please consider injection

DOCTOR'S SIGNATURE

Greater Troch Bursitis

PLACE OF CONSULTATION

☐ BEDSIDE☐ ON CALL☐ ROUTINE☐ TODAY☐ 12 HOURS☐ EMERGENCY

CONSULTATION REPORT

RECORD REVIEWED ☐ YES ☐ NOPATIENT EXAMINED ☐ YES ☐ NO

12/09/97

#01656-087

S: Pain in the left hip for some time. It hurts more when he sleeps on that side. It hurts when he first gets up and starts walking around. Sometimes down the lateral aspect, but mostly fairly well localized. He has had this for sometime. He has been on Motrin for several weeks without any results.

O: On exam he has increased pain with hip flexion and extension, primarily internal rotation. Point area of tenderness attachment of the piriformis tendon.

A: Piriformis syndrome.

P: I will inject the area with Depo-Medrol and Xylocaine. I will give him a prescription for Indocin 50 mg to take b.i.d. for two weeks with one refill. He will lay in for tonight.

ROBERT O. BATEMAN, M.D.

ROB/cb

D: 12/09/97; T: 12/10/97

EASAAD, MD
 Clinical Director

(Continue on reverse side)

SIGNATURE AND TITLE

ROBERT O. BATEMAN, M.D.

IDENTIFICATION NO.

ORGANIZATION

REGISTER NO.

DATE

12/2/97

WARD NO.

PATIENT'S IDENTIFICATION (For typed or written entries give: Name- last, first, middle; grade; rank; rate; hospital or medical facility)

Lee, Paul

01656-087

CONSULTATION SHEET

Medical Record

STANDARD FORM 513 (REV. 8-92)
 Prescribed by GSA/ICMR, FPMR (41 CFR) 201-9.202-1

☆ U.S. GOVERNMENT PRINTING OFFICE 1980-414-308

Federal Correctional Institution
 P.O. Box 1280
 Beaver, WV 25813

MEASUREMENTS AND OTHER FINDINGS

51. HEIGHT 67 1/2 in		52. WEIGHT 222		53. COLOR HAIR Black		54. COLOR EYES Brown		55. BUILD: <input type="checkbox"/> SLENDER <input type="checkbox"/> MEDIUM <input checked="" type="checkbox"/> Y <input type="checkbox"/> OBESE		56. TEMPERATURE 97.4	
57. BLOOD PRESSURE (Arm at heart level)						58. PULSE (Arm at heart level) 84					
A. SITTING SYS. 130 DIA. 90		B. RECUMBENT SYS. DIA.		C. STANDING (5 min.) SYS. DIA.		A. SITTING		B. AFTER EXERCISE		C. 2 MIN. AFTER	
D. RECUMBENT		E. AFTER STANDING 3 MIN.									
59. DISTANT VISION				60. REFRACTION				61. NEAR VISION			
RIGHT 20/25 CORR. TO 20/				BY S. CX				CORR. TO BY			
LEFT 20/30 CORR. TO 20/				BY S. CX				CORR. TO BY			
62. HETEROPHORIA (Specify distance)											
ES*		EX*		R.H.		L.H.		PRISM DIV.		PRISM CONV. CT	
63. ACCOMMODATION		64. COLOR VISION (Test used and result) Normal		65. DEPTH PERCEPTION (Test used and score)		UNCORRECTED				CORRECTED	
RIGHT LEFT											
66. FIELD OF VISION		67. NIGHT VISION (Test used and score)		68. RED LENS TEST		69. INTRAOCULAR TENSION					
70. HEARING		71. AUDIOMETER		72. PSYCHOLOGICAL AND PSYCHOMOTOR (Tests used and score)							
RIGHT WV /15 SV		/15		250 256 500 512 1000 1024 2000 2048 3000 2896 4000 4096 6000 6144 8000 8192							
LEFT WV /15 SV		/15		RIGHT LEFT							

73. NOTES (Continued) AND SIGNIFICANT OR INTERVAL HISTORY

- Deafness in (L) ear. Ashed in 1st or 2nd grade, was told it was nerve damage. Can hear certain tones. Wears glasses for watching T.V
- Injury to (L) rib in 1984. Boxing injury - possible calcific deposits per outside M.D.
- Insulin dependent diabetes in mother, pneumonitis (black lung) - father deceased
- Stutters when nervous since childhood
- S/P tonsillectomy 1971
- S/P vasectomy 1973

(Use additional sheets if necessary)

74. SUMMARY OF DEFECTS AND DIAGNOSES (List diagnoses with item numbers)

Pt. on Benzoyl for maxilla/recently started
15mm @ PPD on 3/12/95
- Umbilical hernia - since childhood, movable
- Hearing loss in (L) ear since childhood. Can hear normal speaking tones.

75. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED (Specify)

- ① Chest X-Ray
- ② Make sure initial breast includes LFT's
- ③ On PPD clinic for f/u
- ④ Audiometry (will schedule)

77. EXAMINEE (Check)

A. ☐ IS QUALIFIED FORB. ☒ IS NOT QUALIFIED FOR find service until ④ PPD evaluated

78. IF NOT QUALIFIED, LIST DISQUALIFYING DEFECTS BY ITEM NUMBER

76. A. PHYSICAL PROFILE

P	U	L	H	E	S

B. PHYSICAL CATEGORY

A	B	C	E

79. TYPED OR PRINTED NAME OF PHYSICIAN

Robin Herman PA-J T MONTGOMERY, FMC PA

80. TYPED OR PRINTED NAME OF PHYSICIAN

J. OLSON, MD
CLINICAL DIRECTOR

82. TYPED OR PRINTED NAME OF REVIEWING OFFICER OR APPROVING AUTHORITY

SIGNATURE

SIGNATURE

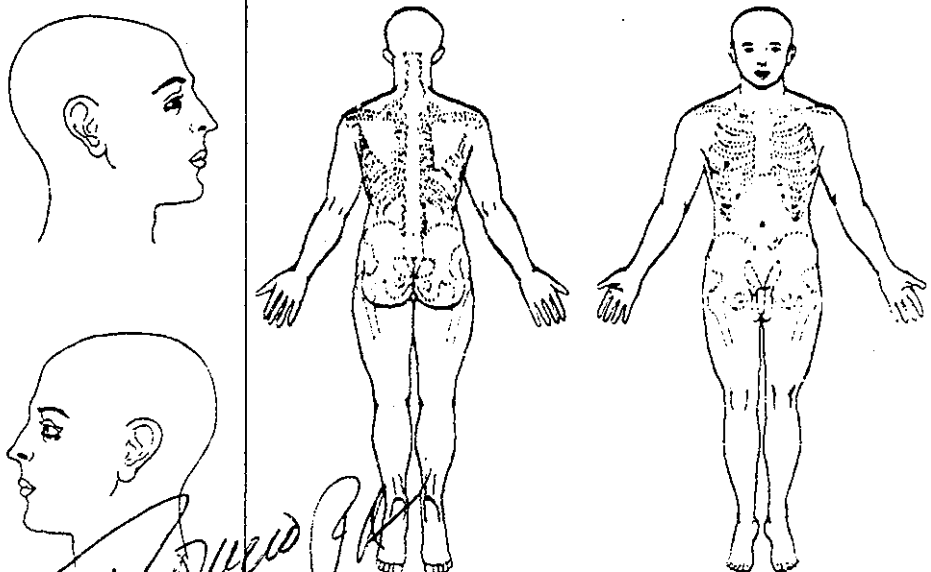
SIGNATURE

SIGNATURE

NUMBER OF ATTACHED SHEETS

U.S. DEPARTMENT OF JUSTICE
Federal Bureau of PrisonsINMATE INJURY ASSESSMENT AND FOLLOWUP
(Medical)

A12

1. Institution FCI-Beckley	2. Name of Injured Lee, Paul	3. Register Number 01656-087
4. Injured's Duty Assignment Bakery	5. Housing Assignment Pop A Lower	6. Date and Time of Injury 10-10-97 1830
7. Where Did Injury Happen (Be specific as to location) Rec Yard	Work Related? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	8. Date and Time Reported for Treatment 10-10-97 1845
9. Subjective: (Injured's Statement as to How Injury Occurred)(Symptoms as Reported by Patient) "I'm Samlock hit me in the shin with his palm" X Ca Signature of Patient		
10. Objective: (Observations or Findings from Examination) 0 injuries observed	X-Rays Taken _____ Not Indicated _____ X-Ray Results	
11. Assessment (Analysis of Facts Based on Subjective and Objective Data) Nothing Found V 71.8		
12. Plan: (Diagnostic Procedures with Results, Treatment and Recommended Follow-up) No Medical Attention		
13. This Injury Required: <input checked="" type="checkbox"/> a. No Medical Attention <input type="checkbox"/> b. Minor First Aid <input type="checkbox"/> c. Hospitalization <input type="checkbox"/> d. Other (explain) <input type="checkbox"/> e. Medically Unassigned <input type="checkbox"/> f. Civilian First Aid Only <input type="checkbox"/> g. Civilian Referred to Community Physician Thompson, RV Signature of Physician or Physician Assistant K S ROSE, RN		

Original - Medical File

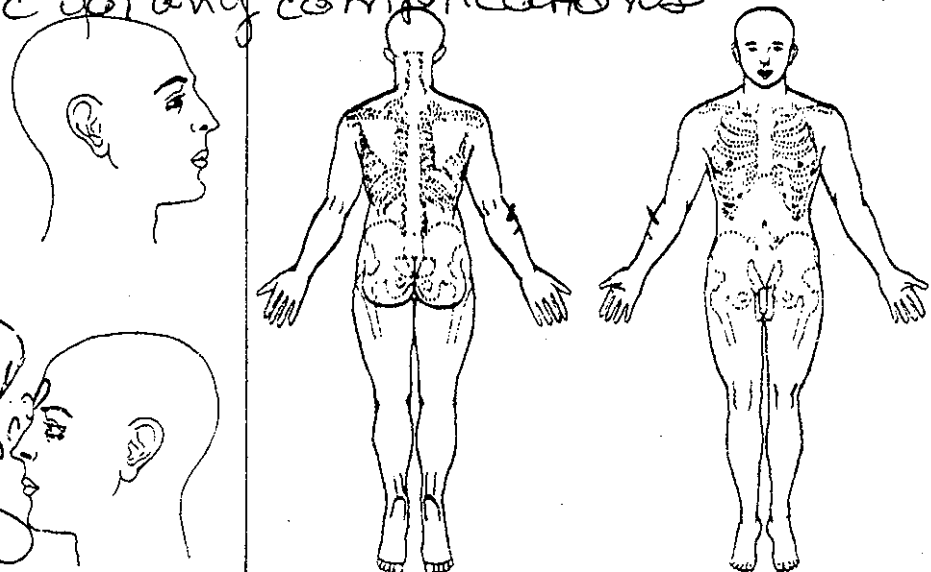
Copy - Safety

Pink - Work Supervisor (Work related only)

Goldenrod - Correctional Supervisor

Self Carboned Form - If ballpoint pen is used, PRESS HARD

U.S. DEPARTMENT OF JUSTICE
Federal Bureau of PrisonsINMATE IN ASSESSMENT AND FOLLOWUP
(Medical)

1. Institution FCT Beckley	2. Name of Injured Lee, Paul	3. Register Number 01656-087
4. Injured's Duty Assignment Bakery	5. Housing Assignment POP A- Lower	6. Date and Time of Injury 10-8-97 @ 0530
7. Where Did Injury Happen (Be specific as to location) Bakery FCT - F/S	Work Related? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	8. Date and Time Reported for Treatment 10-8-97 @ 0630
9. Subjective: (Injured's Statement as to How Injury Occurred)(Symptoms as Reported by Patient) "I burnt my arm on the oven, pulling out a tray."		
Signature of Patient X [Signature]		
10. Objective: (Observations or Findings from Examination) 1" burn to (R) upper fore- arm. & open areas @ this time, minimal swelling area is 4-5cm long by 1cm wide	X-Rays Taken _____ Not Indicated X X-Ray Results	
11. Assessment: (Analysis of Facts Based on Subjective and Objective Data) 949.0 (0) BURNS		
12. Plan: (Diagnostic Procedures with Results, Treatment and Recommended Follow-up) cool H ₂ O applied x 30 min, gently cleansed. silvadene cream applied covered & gauze, secured & tape. Am instructed w: care. ie Drop L&P. s/s of infection		
13. This Injury Required: <input type="checkbox"/> a. No Medical Attention <input checked="" type="checkbox"/> b. Minor First Aid <input type="checkbox"/> c. Hospitalization <input type="checkbox"/> d. Other (explain) <input type="checkbox"/> e. Medically Unassigned <input type="checkbox"/> f. Civilian First Aid Only <input type="checkbox"/> g. Civilian Referred to Community Physician		
Signature of Physician or Physician Assistant [Signature]		

Original - Medical File
 Canary - Safety
 Pink - Work Supervisor (Work related only)
 Goldenrod - Correctional Supervisor

Self Carboned Form - If ballpoint pen is used, PRESS HARD

ENTERED

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
9/15/97 1230 Thurs.	S. LBP O. Full ROM
	Tendr back A. LBP
	P. Motm 400 = TOPIC 30/4
	Heat SCM
	BETTER BETTER
10/14/97	I need melon x my H.P.
0948	PT HAD A DRAINAGE show probably (C) Greater trochanter Bursitis
	-A. Bursitis
	-P. melon 400, if so 720 A 90XI advise to apply heat/warm bath.
	A. L.C. in need. Haddad/HAMMO PA.
2/13/98	S: "I have a problem w. a foot"
0933	O: I have a callus on side of foot.
	A: callus.
	✓-C) shave callus (fine)
	② Holosken.
	③ rec run.
5/11/98 0830	<div data-bbox="1117 1688 1403 1801" data-label="Text"> <p><i>E.J. Chiff</i> E.J. CHIFF, PA</p> </div> <div data-bbox="396 1801 786 1982" data-label="Text"> <p>[NO SHOW] [NO SHOW] <i>Haddad</i> A. HADDAD, PA FPC/FCI BECKLEY</p> </div>

NSN 754C-00-854-4176

HEALTH RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
7/14/97	<p>my (L) side of hip is killing me 1421 a. Pt. with Hx of osteoarthritis & osteoarthritis - P-tyl 1000 mg q 12 hrs for 40 @ advice to apply heat/warm bath and loose band n.t.c. as needed. Hendrickson P.</p>
8-4-97 0854	<p>S.O. hip aching @ hs while standing still Woke @ hs lateral hip @ side On Tender, greater tech - Pain is worse in internal rotation Pain is resisted abduction - SIM intact - No nerve findings A - Hip greater trochanter bursitis T - Motricity is ADP 2/1 - Absorption strengthening @ hip (passive) - Heat TID - Xray if not improving - Ortho Consult for injection / Cancel if better Hendrickson P.</p>

PATIENT'S IDENTIFICATION (Use this space for Mechanical Imprint)

RECORD
MAINTAT
PATIENT

RELATI

SPONSO

DEPART

CHRONO

LEE

PAUL A

B/M/O/04-11-1953

HT/508 WT/205

CUSTODY/IN

01656-087

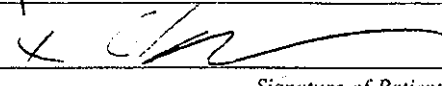
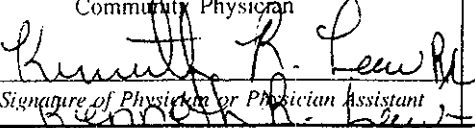
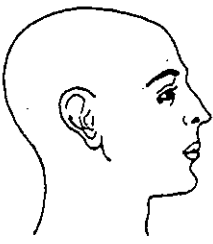
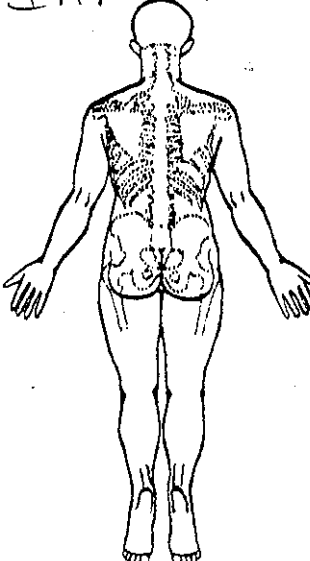
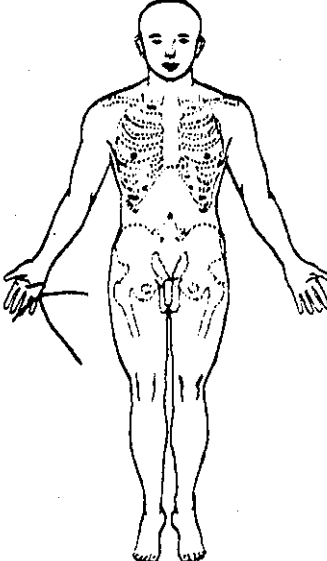
HR/BK EY/BN

NK/GRADE

FE OF BIRTH

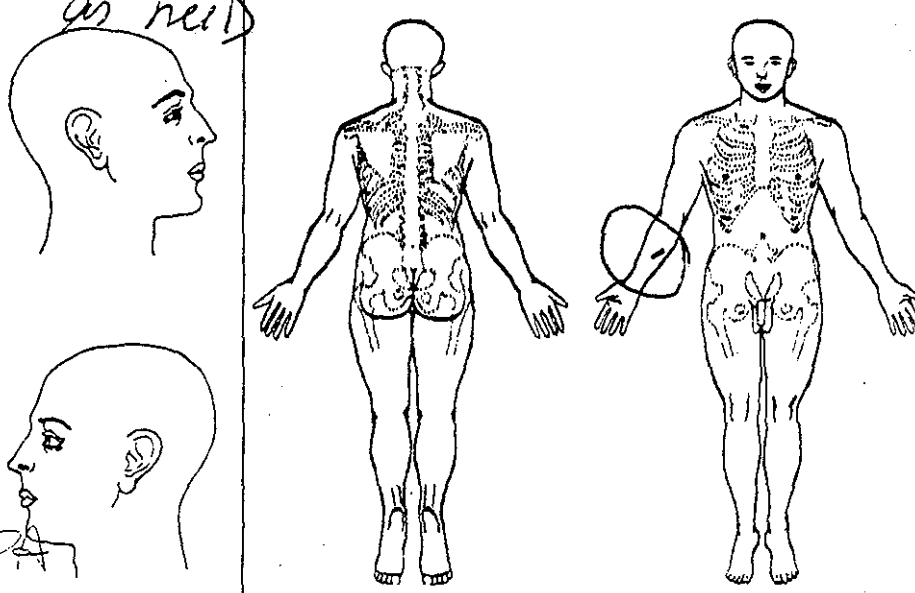
U.S. DEPARTMENT OF JUSTICE
Federal Bureau of Prisons

INMATE INJURY ASSESSMENT AND FOLLOWUP
(Medical)

1. Institution FCI Beckley		2. Name of Injured Lee, Paul		3. Register Number 01656-087	
4. Injured's Duty Assignment Kitchen (dishes)		5. Housing Assignment Pop A-L		6. Date and Time of Injury 8 April 1997 16:15	
7. Where Did Injury Happen (Be specific as to location) Kitchen		Work Related? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		8. Date and Time Reported for Treatment 8 April 1997 16:55	
9. Subjective: (Injured's Statement as to How Injury Occurred) (Symptoms as Reported by Patient) I reached in sink / was cut on Rt hand palm by a pan. X 					
10. Objective: (Observations or Findings from Examination) A/O		X-Rays Taken _____ Not Indicated <input checked="" type="checkbox"/> X-Ray Results _____			
exhibits Superficial laceration to palm of Rt hand (1 1/4 inch) bleeding controlled					
11. Assessment: (Analysis of Facts Based on Subjective and Objective Data) Impaired skin integrity.					
12. Plan: (Diagnostic Procedures with Results, Treatment and Recommended Follow-up) no dishwashing or food prep next 2 days, states he had Tetanus in 1995, area cleaned / collodion flexible applied, watch for any s/s of —					
13. This Injury Required: <input type="checkbox"/> a. No Medical Attention <input checked="" type="checkbox"/> b. Minor First Aid <input type="checkbox"/> c. Hospitalization <input type="checkbox"/> d. Other (explain) <input type="checkbox"/> e. Medically Unassigned <input type="checkbox"/> f. Civilian First Aid Only <input type="checkbox"/> g. Civilian Referred to Community Physician  Signature of Physician or Physician Assistant Kenneth A. Lewis		   Infection.			

U.S. DEPARTMENT OF JUSTICE
Federal Bureau of Prisons

INMATE INJURY ASSESSMENT AND FOLLOWUP
(Initial)

1. Institution FCI Beckley		2. Name of Injured Paul Xee		3. Inmate Number 01656087	
4. Injured's Duty Assignment UNASS.		5. Housing Assignment Pine BL		6. Date and Time of Injury 01/18/97 10:15	
7. Where Did Injury Happen (Be specific as to location) Unit (Pine BL)		Work Related? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		8. Date and Time Reported for Treatment 01/18/97 11:15	
9. Subjective: (Injured's Statement as to How Injury Occurred)(Symptoms as Reported by Patient) I WAS WASHING OFF THE TOP OF MY LOCKER, AND MY RT ARM RAN ACROSS THE OTHER DOOR. Paul Xee Signature of Patient					
10. Objective: (Observations or Findings from Examination)		X-Rays Taken _____ Not Indicated <input checked="" type="checkbox"/> X-Ray Results			
Rt arm have small superficial laceration about 3 cm.					
11. Assessment: (Analysis of Facts Based on Subjective and Objective Data) Laceration Superficial Rt Arm 879.6(X)					
12. Plan: (Diagnostic Procedures with Results, Treatment and Recommended Follow-up) 1. Cleaned with Betadine and polysporin & band with bandage (nipples given) 2. T.T was given 3/15/95					
13. This Injury Required: <input type="checkbox"/> a. No Medical Attention <input checked="" type="checkbox"/> b. Minor First Aid <input type="checkbox"/> c. Hospitalization <input type="checkbox"/> d. Other (explain) <input type="checkbox"/> e. Medically Unassigned <input type="checkbox"/> f. Civilian First Aid Only <input checked="" type="checkbox"/> g. Civilian Referred to Community Physician Duarte-Chip Signature of Physician or Physician Assistant		3. Rtc as need 			

Original - Medical File

Canary - Safety

Pink - Work Supervisor (Work related only)

Goldenrod - Correctional Supervisor

Self Carboned Form - If ballpoint pen is used, PRESS HARD

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (Sign each entry)
7-30-96 0845	BP - 136/76 HR - 65 T - 98.6 - Unable to do Fasting Blood Sugar this Am Pt has already eaten Breakfast.
10/29/96 0943	BP 130/82 HR 74 T 97.5 - Jennifer Puckett RN / Teresa Puckett RN S-F have a rash and thick skin O - Can over 5th pharynx i skin thickening Thick epidermis over medical great toe A - Can P - Numb scales Multiplest Belches JH / R. B. R. R.
01/18/97 11:15	See injury report
8 April 97 18:00	See Injury report for today's date. — — Kenneth R. Law RN — Kenneth R. Law —
4-9-97 1130	Inmate requested a copy of injury report dated 4-8-97. I released 1 copy to inmate J. Aragon J. ARAGON, H.I.T.
04/14/97 0950	TRIAGE < S/ I have cold O/ Fun protein + M. this A/ Common Cold D/ CTM 4 mg i VD. 710 (#15) F/ lenol 500 mg TT PD. 710 A intake 11

NSN 7540-00-834-4178

HEALTH RECORD

CHRONOLOGICAL RECORD OF MEDICAL CARE

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT TREATING ORGANIZATION (Sign each entry)
3/27/96 C720	<p>S- 42 yo B^M presents w/ 1-2d H/o sore dry throat Initial onset 2 dry scratchy throat & progression -> soreness. 4-2 day non-productive cough. No current chills however positive previous chills!</p> <p>O- ax ax B^M AOT: 98.4</p> <p>Oropharynx hyperemic & moist. Throat PND -> adenopathy</p> <p>Lungs c/o a/c. Trachea B/c</p> <p>no murmurs or focal areas tenderness.</p> <p>neck soft & supple</p> <p>A. Pharyngitis</p> <p>P- Amoxicillin 500 PO q8 x 10d #30</p> <p>OTC 4 mg BID x 7d #14</p> <p>Saline Sprays</p>
7-28-96 0900	<p>S- "Had Sharp Pains in my Chest q/t & on Since 0300 this AM!"</p> <p>O- BP 118/82 HR 72 Respiration unlabored rate 16</p> <p>Skin w/o Diarrhea pain at this time EKG Done No Acute Abnormalities noted. Nocturnal</p> <p>A- Alteration in Comfort</p> <p>P- Encouraged to report to sick call for further Eval. then continue to monitor as ordered. Encouraged to return if CP comes back. - J. Beckley MD / Tensat Park</p>

PATIENT'S IDENTIFICATION (Use this space for Mechanical Imprint)

RECOR
MAINTA

AT:

PATIENT

RELAT

SPONSOR

DEPART.

CHRONO

LEE

PAUL A

B/M/O/04-11-1953

HT/508 WT/205

CUSTODY/IN

01656-087

HR/BK EY/BN

JK/GRADE

FE OF BIRTH

D/REV 5.8A1

FCI BECKLEY, WV

FIRM

67

Pharmacy Services
FCI BECKLEY, WV 25813 304-255-7731

RX400012485 G. BETTS 10/29/96
LEE, PAUL 01656-087
CUT PLASTER TO FOR ITCHING CORN AND APPLY
REMOVE AFTER 48 HOURS

SALICYLIC ACID PLASTER #1
SD 0 REFILL(S) EXPIRES 11/28/96

Pharmacy Services
FCI BECKLEY, WV 25813 304-255-7731

RX400020725 A. DUARTE-CHIFI 04/14/97
LEE, PAUL 01656-087
TAKE 1 TABLET BY MOUTH EVERY 4 HOURS AS
NEEDED (DO NOT TAKE MORE THAN 8 TABLETS PER 24
HOURS)

CHLORPHENIRAMINE MALEATE 4 MG TABLET #15
SD 0 REFILL(S) EXPIRES 05/14/97

Pharmacy Services
FCI BECKLEY, WV 25813 304-255-7731

RX400020726 A. DUARTE-CHIFI 04/14/97
LEE, PAUL 01656-087
TAKE 1 OR 2 TABLETS BY MOUTH EVERY 4 TO 6 HOURS
AS NEEDED (DO NOT EXCEED 8 TABLETS PER DAY)

ACETAMINOPHEN 500 MG TABLET #20
SD 0 REFILL(S) EXPIRES 05/14/97

Pharmacy Services
FCI BECKLEY, WV 25813 304-255-7731

RX400024946 A. HADDED 07/14/97
LEE, PAUL 01656-087
TAKE 1 OR 2 TABLETS BY MOUTH EVERY 4 TO 6 HOURS
AS NEEDED (DO NOT EXCEED 8 TABLETS PER DAY)

ACETAMINOPHEN 500 MG TABLET #40
SD 0 REFILL(S) EXPIRES 08/13/97

Pharmacy Services
FCI BECKLEY, WV 25813 304-255-7731

RX400028025 G. BETTS 09/15/97
LEE, PAUL A. FCI 01656-087
TAKE 1 OR 2 TABLETS BY MOUTH EVERY 4 TO 6 HOURS
AS NEEDED FOR PAIN WITH FOOD (DO NOT EXCEED 8
TABLETS PER DAY)

IBUPROFEN 400 MG TABLET #30
SD 0 REFILL(S) EXPIRES 10/15/97

Pharmacy Services
FCI BECKLEY, WV 25813 304-255-7731

RX400025979 G. BETTS 08/04/97
LEE, PAUL A. FCI 01656-087
TAKE 1 OR 2 TABLETS BY MOUTH EVERY 4 TO 6 HOURS
AS NEEDED FOR PAIN WITH FOOD (DO NOT EXCEED 8
TABLETS PER DAY)

IBUPROFEN 400 MG TABLET #30
SD 1 REFILL(S) EXPIRES 10/03/97

Pharmacy Services
FCI BECKLEY, WV 25813 304-255-7731

RX400029585 A. HADDED 10/14/97
LEE, PAUL A. FCI 01656-087
TAKE 1 OR 2 TABLETS BY MOUTH EVERY 4 TO 6 HOURS
AS NEEDED FOR PAIN WITH FOOD (DO NOT EXCEED 8
TABLETS PER DAY)

IBUPROFEN 400 MG TABLET #20
SD 1 REFILL(S) EXPIRES 12/13/97

Pharmacy Services
FCI BECKLEY, WV 25813 304-255-7731

RX400032098 Dr. E. ASAAD 01/14/98
LEE, PAUL A. FCI 01656-087
TAKE 2 CAPSULES BY MOUTH TWICE A DAY WITH FOOD

INDOMETHACIN 25 MG CAPSULE #56
SD 1 REFILL(S) EXPIRES 01/07/98

Pharmacy Services
FCI BECKLEY, WV 25813 304-255-7731

RX400039931 E. ROMERO 05/14/98
LEE, PAUL A. FCI 01656-087
TAKE 1 OR 2 TABLETS BY MOUTH EVERY 4 TO 6 HOURS
AS NEEDED FOR PAIN WITH FOOD (DO NOT EXCEED 8
TABLETS PER DAY)

IBUPROFEN 400 MG TABLET #28
SD 0 REFILL(S) EXPIRES 06/13/98

Pharmacy Services
FCI BECKLEY, WV 25813 304-255-7731

RX400044470 E. CHIFI 08/14/98
LEE, PAUL A. FCI 01656-087
TAKE 1 CAPSULE BY MOUTH TWICE A DAY ON AN EMPTY
STOMACH UNTIL FINISHED

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF PENNSYLVANIA

PAUL LEE,

Plaintiff

v.

UNITED STATES OF AMERICA, et al.
Defendants

:
:
:
:
:
:
:

Civil No. 1:CV-00-00486
(Kane, J.)

CERTIFICATE OF SERVICE BY MAIL

The undersigned hereby certifies that she is an employee in the Office of the United States Attorney for the Middle District of Pennsylvania and is a person of such age and discretion as to be competent to serve papers.

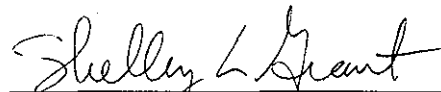
That on December 11, 2000, she served a copy of the attached

**RECORD TO BRIEF IN SUPPORT OF THE DEFENDANTS'
MOTION FOR SUMMARY JUDGMENT**

by placing said copy in a postpaid envelope addressed to the person hereinafter named, at the place and address stated below, which is the last known address, and by depositing said envelope and contents in the United States Mail at Harrisburg, Pennsylvania.

Addressee:

Paul Lee
Reg. No. 01656-087
FCI Allenwood
P.O. Box 2000
White Deer, PA 17887



SHELLEY L. GRANT
Paralegal Specialist